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# THERE'S NO PLACE LIKE HOME: HOME HEALTH CARE IN RURAL AMERICA

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BEFORE THE

## SPECIAL COMMITTEE ON AGING

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# C O N T E N T S

# THERE'S NO PLACE LIKE HOME: HOME HEALTH CARE IN RURAL AMERICA

**WEDNESDAY, FEBRUARY 12, 2020**

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
*Washington, DC.*

The Committee met, pursuant to notice, at 9:02 a.m., in Room SD-366, Dirksen Senate Office Building, Hon. Susan M. Collins, Chairman of the Committee, presiding.

Present: Senators Collins, Hawley, Braun, Rick Scott, Casey, Gillibrand, Blumenthal, Jones, Sinema, and Rosen.

## OPENING STATEMENT OF SENATOR SUSAN M. COLLINS, CHAIRMAN

The CHAIRMAN. The Committee will come to order.

Good morning. Let me explain to everyone the early start for this hearing. The Senate has scheduled a series of votes to begin at 10:30. We did not expect that and we had witnesses on the way, so we did not want to postpone the hearing, so I am going to start with my opening statement. I expect the Ranking Member, Senator Casey, will be here shortly, and when he is able to get here I will interrupt the hearing and allow him to deliver his opening statement but I want to thank all of our witnesses and those who are here today for your flexibility. Unfortunately, I do not control the floor schedule, and usually our votes are in the afternoon, not the morning, but today is different.

First, let me bid you all a good morning. Year after year, when seniors are asked how they want to spend their golden years, they overwhelmingly answer "at home." Today's hearing will focus on how we can better help our seniors achieve that goal.

I saw first-hand the importance of home care in my very first home visit during my second year of Senate service. In my hometown in Aroostook County I saw how home health care allowed an older couple in their 80's to spend the rest of their lives together in the comfort, security, and privacy of their own home. They were worried that otherwise they would be separated and one of them living in a nursing home. I remembered them telling me that all they wanted was to spend the rest of their lives together in their own home.

Highly skilled and caring visiting nurses make such a difference in the lives of patients and families like this couple. In Maine, home health workers often go to extraordinary lengths for their rural patients, sometimes relying on lobster boats and mail planes to reach them.

Home health care not only helps seniors live in the comfort of their own homes but it also saves money. According to research from the University of Rochester, older adults who receive one to two hours of in-home physical therapy, for example, are up to 82 percent less likely to face hospital readmissions 60 days after discharge. Studies from post-acute care discharge patterns have shown that clinically appropriate deployment of home health care can yield potential savings of more than $32 billion over 10 years.

In the face of workforce shortages and payment cuts, today's hearing will highlight challenges that are facing the home health community. For those in rural areas where more than one in five older adults live, home health can be a lifeline, and we must do more to meet growing needs.

As we look to the future, the demand for home health services will only continue to grow as our population ages. According to the Bureau of Labor Statistics, the need for home-based aides is projected to grow by 97 percent over the next 10 years, making it the third-fastest-growing occupation.

Yet while we recognize the value that home health can provide, many home health agencies are struggling in the current reimbursement and regulatory environment, precisely at the moment when we need their services more than ever.

I am concerned about the implementation of the new patient-driven groupings model and the ability of rural agencies to absorb preemptive rate cuts of more than 4 percent based off assumptions that somehow agencies will try to maximize reimbursement.

Agencies have weathered several years of reimbursement reductions through both regulatory changes as well as sequestration, and we cannot assume that they can continue to provide the same level of home health services at reduced rates. That is why I have introduced the Home Health Payment Innovation Act, which has been co-sponsored by 31 Senators, including committee members Tim Scott, Jones, Sinema, Burr, Rosen, and Rubio. My legislation would prevent further inequitable payment rate cuts. It would provide flexibility on waiving the homebound requirement for services.

According to a survey of home health administrators by the Walsh Center for Rural Health, more than two-thirds reported that there were rural patients who could benefit from home health services but simply did not meet the criteria for being homebound. Furthermore, one-third reported that it could be inconvenient or even dangerous for some senior patients to be driving. However, because they did not drive, they did not qualify for services—because they did drive, they did not qualify for services.

As home health agencies are adjusting to the new payment system, I believe that Congress should revisit the rural add-on payment. A well-targeted rural add-on payment is especially needed now, and it is needed to compensate home health agencies that are operating in vast rural areas, such as northern Maine, where they have to drive long distances between patients.

I have also introduced the Home Health Care Planning Improvement Act, which has 41 co-sponsors, including Senators Casey, Sinema, and Gillibrand. This bill would improve the access Medicare beneficiaries have to home health care by allowing physician assistants, nurse practitioners, and clinical nurse specialists to

order home health care services. That would be particularly helpful in rural and underserved areas of our Nation.

In many instances in rural areas, a patient's primary health provider may not be a physician. Yet today only physicians are allowed to certify home health care for Medicare patients, even though they may not be the most familiar with the patient's case. In fact, they may not be familiar at all with the patient or his or her condition.

These requirements create obstacles, delays, and administrative burdens to receiving home health care services. Last summer, Health Affairs featured an article that put a human face on the unintended consequences of its policy. A rural patient waited several days before a physician was available to sign an order for home health care. By that time, an open wound on his hip had doubled in size and deepened. Instead of taking two to 3 weeks to heal it took nearly 3 months, so this policy has real consequences for the health of our patients. By helping patients to avoid more costly hospital visits and nursing homes, home health saves Medicare, Medicaid, and private insurers millions of dollars each year and allows seniors to age in the comfort and security of their own homes.

I have never understood why administration after administration targets home health care for reimbursement cuts. If there are bad apples in the industry, go after those agencies. Do not penalize everyone. That makes no sense whatsoever when home health care reflects the choice that the patient wants and is the most appropriate care, and saves money.

I am looking forward to hearing from each of our witnesses today, and I am going to introduce our witnesses, and as I said, when Senator Casey arrives we will interrupt and have him deliver his opening statement.

First I am very pleased to welcome Leigh Ann Howard from the great State of Maine. Leigh Ann is the Director of Home Health and Specialty Programs at Northern Light Home Care & Hospice. In this capacity, she is responsible for directing the development of new and innovative telemedicine and health programs. I am really interested in telemedicine and what that could do to help solve some of the distance problems that we have.

Leigh Ann has been on the forefront of bringing telemedicine and home health to Mainers, and I am delighted that she is able to be with us today.

Next we will hear from William Dombi. I know Bill very well and have worked with him for many years. He is the President of the National Association for Home Care & Hospice. This association represents more than 33,000 home care and hospice providers, as well as more than 2 million nurses, therapists, and aides that they employ nationwide. He is also the Director of the Center for Health Care Law and Executive Director of the Home Care & Hospice Financial Managers Association. He is a longstanding champion in the field of home care.

Next we will hear from Dr. Warren Hebert. I told Dr. Hebert that because I am from northern Maine I know how to pronounce his last name, since Louisiana and Northern Maine both have a lot of Acadian influence. He is an Assistant Professor as well as being the CEO of the Home Health Care Association of Louisiana. He has

worked in home care since 1985, and has offered his expertise to panels and reports for many institutions, including the Institute for Medicine and CMS.

Our final witness is from Pennsylvania. Mr. Francis Adams is a home care worker from Washington, Pennsylvania. I know that Senator Casey has a fuller introduction of you that he will want to give, so I will hold up but express my gratitude for your being here today as well.

Ms. Howard, we are going to start with you.

**STATEMENT OF LEIGH ANN HOWARD, RN, DNP, CHFN-K, DIRECTOR, HOME HEALTH AND SPECIALTY PROGRAMS, NORTHERN LIGHT HOME CARE & HOSPICE, WATERBORO, MAINE**

Ms. HOWARD. Chairman Collins, Ranking Member Casey, and members of the U.S. Senate Special Committee on Aging, good morning. My name is Leigh Ann Howard and I want to thank you for this opportunity to speak to you today to share our experiences as a provider of home health care in rural America.

I currently serve as the Director of Home Health and Specialty Programs at Northern Light Home Care and Hospice, which a Medicare-certified home care and hospice agency. As a member of Northern Light Health, a Maine-based integrated health care system, our home health and hospice programs provide care throughout the entire State of Maine. Maine citizens are among the oldest in the country living in a large rural geography.

Over the last year, Northern Light Home Care and Hospice clinicians drove over three million miles to provide care, making close to 200,000 home care and hospice visits. At times the transportation to get to these patients' homes is just as unique as the geography of the State of Maine.

For example, to serve many of our island communities off the coast of Maine, our clinicians need to travel by lobster boat or mail boat as this is the only way to access the island. This time of year, our staff may have to shovel their way down a long snowy driveway to reach the front door.

Traveling the winding back roads in unpredictable weather conditions of western Maine also brings another layer of challenge, and many times the travel time between each patient can be an hour or more.

As Maine's rural population continues to decline, so do the number of qualified health care professionals. Health care workforce shortages have reached critical levels in our State. Not only do we experience a significant nursing workforce shortage but also in primary care physicians. Nurse practitioners many times are the only primary care clinicians in our rural areas. Unfortunately, Federal law prohibits those nurse practitioners and physician assistants from ordering home health services.

Recently we received a referral for a patient who had just been discharged from the hospital. He needed home health and physical therapy services. We worked for over 2 weeks with the patient's nurse practitioner to try to find a physician who would sign for the home health care that he needed. Some patients are even readmitted to the hospital before we can even find a physician who will sign for the plan of care.

Rural residents already face many challenges to accessing the care they need and it is important that we remove those barriers to be able to allow them to access health care, regardless of where they live.

Recent changes in Medicare, brought by PDGM have driven home the importance to us of collaboration between our home care staff, patients, physicians, and our patients' families. We are focused on how technology helps us to achieve the best collaboration with all of them.

To focus on this, we have realized a significant success with our home telemonitoring program. This services places technology in the patient's home where they check their weight, their blood pressure, and their heart rate. That information is then transmitted to a web-based portal, either by cell signal or by the patient's home Wi-Fi.

This information is then reviewed daily by the nurse. The telemonitoring nurse can then act on those readings, whether it is calling the patient to investigate the symptoms further, calling a physician, and collaborating with a physician to make medication adjustments, all while the patient is still remaining in the home.

Our telemonitoring program has realized a rehospitalization rate of between 2 to 4 percent, which when compared to the national average or 24 percent rehospitalization rate for heart failure patients is a significant improvement.

One patient we have been seeing for a number of years, before coming on to a telemonitoring program, had over 20 ER and hospitalizations over a matter of 6 months. While working with our health care clinicians, our telemonitoring program, and our physicians, we were able to significantly decrease her rehospitalization rate, and most importantly, we have kept her in her home for over 5 years.

Telemonitoring services are not reimbursed by Medicare but it is allowable in the episodic payments for home health. However, we need to always continue to move to a discharge with those patients, and with that we need to remove that equipment that is in the home, which then brings that patient to be at a significant risk of being readmitted to the hospital. We are removing a device or a product that is helping us to be able to identify symptoms early, treat them in the home or in the physician's office, and out of the ER or the hospital.

Connectivity is also a challenge in our State. There are significant areas with little to no cell coverage, poor or no broadband access, and sometimes the cost of those services is just more than a patient can afford, and this also prevents us from continuing to move forward with video-based home visits.

Other services that we think would help to keep our patients in their home longer are home-based pharmacists visits, as many of our patients experience polypharmacy, taking more than 25 medications.

Again, I am so honored to be here today to be able to share our work with you, and I just thank you for this awesome opportunity.

The CHAIRMAN. Thank you very much for your testimony. I am now going to turn to our Ranking Member for his opening state-

ment and to complete the introduction of Mr. Adams, who I introduced just briefly in anticipation of your arrival. Thank you.

**OPENING STATEMENT OF SENATOR ROBERT P. CASEY, JR., RANKING MEMBER**

Senator CASEY. Chairman Collins, thanks very much. I apologize for being late. We had a scheduling change and I am sorry for that delay.

I am pleased that the Committee today has convened to discuss the important issue of access to health care, particularly home health care and rural communities. From Washington County, which is in southwestern Pennsylvania, where our witness, Mr. Adams, is from, from that county to Wayne County, way up in northeastern Pennsylvania, near where I live, there is about 350 miles of road through rural Pennsylvania. We know from research that people who live along that stretch of road and along rural roads across the country are more likely to be older, to be sicker, and to be less well off than their peers, and as a result they require more health care services.

I visited with seniors and people with disabilities in at least 33 of our 67 counties in the last couple of years. One of the constants I hear is that they prefer to age and receive services and supports in their homes and in their communities. Due to transportation constraints and travel distances, accessing those services can be challenging, and that is an understatement. That is especially true for seniors and people with disabilities living in rural areas of our State and our country.

They tell me that they skip medical appointments because there is no affordable or easy way to make the trip. This can lead to even greater disparities and even worse health outcomes. In an effort to meet people where they are and keep them healthier longer, we must make investments to expand access to rural health services at both the macro level and micro level. We must ensure that individuals and families have affordable health care.

It is why I have been fighting to protect the Affordable Care Act and Medicaid from cuts by the Administration and sabotage. We must protect Medicare from the half a trillion dollars in budget cuts that have been recently proposed by the Administration. We must support rural hospitals. That is why I introduced the Rural Hospital Sustainability Act, which provides stable funding for rural hospitals, allowing hospitals to redesign their care and remain open in rural communities, and we must invest in home health care. I am introducing the Home and Community-Based Services Infrastructure Improvement Act. This bill will provide Medicaid grants to all states to support existing service providers, and encourage the creation of new delivery systems to meet the needs of older adults and people with disabilities. The bill provides states with funds to support more accessible transportation and housing. It will also incentivize states to increase wages and benefits for direct care workers, people like Mr. Adams, who is with us today, and others who do that difficult work in rural communities.

In our State of Pennsylvania, over 13,000 older adults and people with disabilities are waiting—waiting for home and community-based services. Across the country, that number is more than

700,000 people waiting. My bill aims to change that to make home-based care and services a reality for all those who need it. An investment in home care is an investment in the future of rural America. It is also an investment in our care, our workforce, and our economy.

Madam Chair, thank you, and I will do the introduction now?

The CHAIRMAN. That would be great.

Senator CASEY. Thank you so much. I am here to introduce, as Chairman Collins noted, and as she began to introduce, and I am grateful for that part of the introduction, Mr. Francis Adams of Washington, Pennsylvania, as I said, in the southwestern corner, just south of Pittsburgh. He is a home care worker with over 20 years of experience working in rural Pennsylvania, of which I just spoke.

He began his home care work taking care of his grandfather who suffered from black lung disease from the coal mines, and too many families and retired coal miners in states like mine suffer from black lung. Mr. Adams is also a third-generation union member, a proud member of the United Home Care Workers of Pennsylvania, a joint program of SEIU Healthcare Pennsylvania, and the AFSCME union.

Mr. Adams' father was a steelworker and his mother was a teacher, and as I said, his grandfather was a coal miner. They are all proud union members. He will share with us the difficulties facing home care workers in rural communities and the steps we can take to better serve rural seniors and people with disabilities in rural America and rural Pennsylvania.

Mr. Adams, thanks for being with us today. We look forward to your testimony.

Thank you, Madam Chair.

The CHAIRMAN. Thank you very much. Mr. Dombi.

**STATEMENT OF WILLIAM DOMBI, PRESIDENT, NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE, WASHINGTON, D.C.**

Mr. DOMBI. Thank you, Chairman Collins and Ranking Member Casey, and the remainder of the Senate Aging Committee for the opportunity to be with you today to testify at this very important hearing.

Since the beginning of Medicaid, the home health care benefit has had a special place in that program. Most notably, it is the only benefit that is available under both Medicare Part A and Part B. Medicaid itself also has led the charge in rebalancing long-term services supports into the home care setting. Still, there is room to modernize the Medicaid home health benefit and to expand home care options in Medicaid.

To start with, the Home Health Care Planning and Improvement Act, which is co-sponsored by Chairman Collins and Mr. Casey as well, Ranking Member Casey, is one of the crucial modernizations that is needed. We thank you for your longstanding sponsorship in support of that bill, which began in 2007.

It is certainly time to revise Medicare to permit the over 200,000 non-physician practitioners in primary care practice to certify Medicare benefit eligibility instead of limiting such to physicians.

S. 296 would improve program integrity as it is compromised when the patient is handed off to a physician for the sole purpose of meeting Medicare certification requirements. The bill would also enhance quality of care as it would no longer be necessary to insert a physician who has not cared for the patient into the patient care process.

Finally, there would be cost savings, since Medicare reimbursement rates for non-physician practitioners are less than payment rates for physicians, but more importantly, costs would be reduced as it avoids duplicative paperwork.

Today the legislation is supported by numerous patient advocacy groups, health care professionals, and physician groups as well. There is an obvious reason why there has been such widespread support. Our nation depends on non-physician practitioners every day. It is now time to pass S. 296 and bring the long-overdue modernization of the home health benefit requirements into reality. In 2007, when such legislation was originally introduced, the reform may have been considered innovative. In 2020, it is a necessity.

Number two, we suggest reinstating the Medicare home health rural add-on. The longstanding rural add-on for home health services will be phased out completely in 2022, threatening the provision of home health benefit in rural areas. Since the 1990's, the home health service payment system has recognized the special needs of rural areas as there are higher travel times, travel costs themselves, and often the need for an extended duration of the service visit. The absence of physicians in rural areas, along with hospital closures, compound the problems of care delivery.

The latest data available shows that home health agencies located in rural areas receive an average of 6.2 percent less than their cost of care. Most notable is that nearly 40 percent of these providers have Medicare margins below zero. Targeting an add-on may be considered as the current legislation does, but the current approach does not work, with 38 to 69 percent of agencies affected by that in the respective target categories being paid less than their cost of care.

We recommend that Congress reinstate the 3 percent rural add-on for 3 years and require an expanded study to determine whether targeting is warranted.

Number three, the new home health payment model, the PDGM as we call it, took effect January 1 of this year. It includes a preemptive first-year reduction in base payment rates of over $750 million, derived solely from assumptions as to how home health providers might behave in their provision of care and documentation practices.

We strongly supported the Home Health Payment Innovation Act, S. 433, as introduced by Senator Collins last year. While that proposal may need now some refinements given the issuance of the 2020 rule, Congress should call on Medicare to improve transparency and restrict the use of bald assumptions in setting payment rates.

It would also be very helpful if Congress committed to closely monitoring access to care and changes in service utilization. There are clearly anecdotal reports of access problems for patients in cat-

egories with reduced reimbursement levels to home health agencies already, in just a little over a month of this new program.

To finish with just two other items, innovation telehealth. Ms. Howard gave all the information necessary to justify that. We wholly support moving forward with any steps to provide for remote monitoring the patients and other telehealth services in rural areas and in the rest of the country. Among the steps to be taken would be to increase the availability of broadband for the ability of those technologies to actually work, and finally, workforce. You know, I look forward to listening to the discussions regarding the workforce. There is no delivery of home health services without the workforce and we have a shortage of nurses, which continues to expand, and even a greater shortage of personal care attendants to deliver the services to individuals who need support with activities of daily living. We need a national solution to this and we need it soon, because the aging of our population as well as the growing number of persons with disabilities cannot make it in the home without that support.

Thank you for the opportunity to come here today.

The CHAIRMAN. Thank you very much, Mr. Dombi.

Mr. Hebert, and I am going to ask you to turn on your mic. Thank you.

**STATEMENT OF WARREN HEBERT, DNP, RN, CAE, FAAN, ASSISTANT PROFESSOR, LOYOLA UNIVERSITY, AND CEO, ASSOCIATION OF HOME HEALTH CARE, LAFAYETTE, LOUISIANA**

Mr. HEBERT. Thank you. "My histories and physicals are incomplete until I have had a chance to have a meal at the table with their family and the patient." Those words were made famous by Dr. Patch Adams. Patch Adams, a West Virginia physician, was made famous by Robin Williams in the movie named Patch Adams.

Dr. Adams understood rural home health care. He knew that he did not have a complete picture of the patient and their situation until he saw them in their home. This is one of the advantages that rural home care agencies have and those that are providing rural home and community-based services, and a lot of those folks that are doing that are nurse practitioners, because physicians cannot be in those rural areas.

The access to the home is extremely important and social determinants of health, that we have talked a lot about over the past few years, are certainly very important in our rural areas.

There is much to be joyful and thankful about in our rural areas. The peaceful drive through the countryside of the mountains of Maine, down in south Louisiana the swamplands and the marshes, and you just had the Washington, D.C., Mardi Gras, so you probably know that this is crawfish season in Louisiana, and we are seeing crawfish ponds as we drive along.

Our patients in rural areas live there, in those places. A trained eye visiting those places can do what is called a windshield survey. As we are driving into the area we can see a lot of the public health issues that exist. We can understand the socioeconomic challenges that are in that area.

When I knock on a patient's door and cross that sacred threshold into their home, health care is very different than it is with our

friends in the acute care settings. It is their place. It is their territory. As I walk in the house I know a little bit about how the patient and their family are going to engage me. That tells me a lot, related to my assessment. I can look at the pictures on the walls and find out what sort of support they have within their family unit, and I will speak to family caregivers a bit in a few minutes, and if that first visit goes well I might be offered a cup of coffee. That happens a lot in rural homes and if I am really good at building a relationship they will invite me to have a look into their refrigerator and their pantry.

Madam Chair, Ranking Member Casey, Senators and hard-working staff, you know, as my colleagues are I am honored to be here with you and dive into some of the challenges around rural health care.

Depending on the resource one cites, as many as 45 million family caregivers are taking on challenges alone across the country with very little support. In rural areas, families are very fortunate if they are able to have home and community-based services or they are able to have home health care assisting them. On occasion, we have nurse practitioners making visits to patients in their home. That is a real gift and we are very fortunate that we have nurse practitioners who are willing to do that critical work.

AARP reports that daily between 7 and 8 million people are providing care as family caregivers, and again, most of the time they are unsupported, so it is critical for us to understand the work that your Committee is doing, Madam Chair, and the need to support that.

Within my own family, my wife and I are very fortunate to have a 29-year-old daughter who has Down syndrome, so besides being on the provider side we are also consumers in that she receives home and community-based services. My dad had dementia for 7 years. We were fortunate that Mom and Dad prepared for their senior years.

I am the oldest of 10 children, and in south Louisiana people do not wander too far from home, so the 10 of us all lived within 20 minutes of Mom and Dad. Over his 7 years with dementia, Dad did not spend one night in a hospital or a nursing home, because we were able to help my extraordinary mother with Dad's work.

These are the sort of challenges that rural families are dealing with, but the rural families are not experiencing the same ability to connect as they did in the past. We are having challenges that as conglomerates are taking over a lot of rural farms, those farm families are needing to move and find jobs in suburban and urban areas, so as a result, the tax base is drying up in those communities. As the tax base dries up, schools, hospitals, physicians, pharmacists, et cetera, are all having to close.

In closing, I would like to quote Dr. Joseph Coughlin, of MIT's AgeLab. About a year ago he tweeted that when it comes to aging, independence is overrated. It is interdependence that we should be seeking.

I hope that in this hearing we can be more vibrant and have a lively conversation about interdependence. That is a critical conversation for people who need home care in rural communities.

Thank you, Madam Chair.

The CHAIRMAN. Thank you very much, Doctor. Mr. Adams, welcome.

**STATEMENT OF FRANCIS ADAMS, HOME CARE WORKER, WASHINGTON, PENNSYLVANIA**

Mr. ADAMS. Good morning. My name is Francis Adams. I am a home care provider from Washington, Pennsylvania. I am also a proud member of the United Home Care Workers of Pennsylvania, a joint program with SEIU Care, and AFSCME.

I have been helping seniors and people with disabilities who live at home for over 20 years. I left my job as a steelworker to care for my grandfather when he fell ill from black lung. I later cared for my aunt. I wanted to be there for my family. That is when somebody told me that home care can be a career. I really liked the work and people needed it.

Every day, more than 10,000 people turn 65 in America. We need to attract 1 million more workers to this industry by 2026 to meet the demand. However, our current long-term care system does not support home care workers or our clients.

Presently I care for my brother, who is blind. I am also a on-call home care worker, stepping in at all times when a client's regular caregiver is unavailable. Many of my clients do not have anyone else. A lot of my job duties are physical—bathing, cooking, cleaning, driving to appointments—but it is the emotional connection that really makes the impact.

I never want to leave a client alone. Depression can kill you as quickly as lung cancer and because I work on call, oftentimes I do not know what equipment someone has in their home. That is why training is so important.

Washington, Pennsylvania, is not like D.C. It is a rural area. We cannot cross the street to get to the grocery store or hop on a subway to get across town. Neighbors are separated by several miles. It takes much longer for fire trucks and ambulances to get those in need. Distance and mobility issues sometimes leave my clients running out of vital supplies. I make sure they have them.

Home care work was a lifeline for me, after working at the mills. My pension was only a small fraction of what had been promised to me, so I need this job. I make $10.70 an hour and I work 10 to 40 hours any given week. In addition to being a home care worker, at age 70 I have a second job in retail to make ends meet. If home care paid more, I would not have to take on other work.

It is not that we do not have enough people to do home care that creates a shortage. It is that our country undervalues this work. We have to fix this. That is why I am joining Pennsylvania home care workers fighting for higher wages and a union. With a union we have the strength in numbers to negotiate wages, basic benefits, and training. We have worked together to strengthen Pennsylvania's Medicaid program, and importantly, my union has given me a sense of community.

My grandfather, my father, my mother were union members. I saw what the unions do to improve our lives. Unions advocate for racial and social justice. My family marched with Dr. King and I held that passion as I grew older. As a child I saw firsthand the

shameful legacy of Jim Crow that held hardworking people in my community back.

The legacy continues in home care, a job that has historically been mislabeled as unskilled. We must move past this institutional racism so that in 20 years home care is a well-respected, sought-after, family sustaining job. Home care is the country's future. Home care jobs must be good jobs, union jobs, and workers must make at least $15 an hour and have affordable health care.

When we invest in our home care workforce we can improve our long-term care system for all. Thank you.

The CHAIRMAN. Thank you very much, Mr. Adams.

Ms. Howard I want to start with you. Home health agencies in Maine and across the Nation have had to weather a series of Medicare reimbursement reductions from the reimbursement payment cuts that were contained in the Affordable Care Act to the latest negative 4-plus percent behavioral adjustment cut.

I would like you to describe what the impact is on home health agencies in Maine. I know I read that a very large agency recently closed, that was serving nearly 600 patients, so what is the impact of inadequate reimbursements, whether it is under the Medicaid program or the Medicare program?

Ms. HOWARD. Sure. A number of things are happening, so as you know, there are closures. There are also a number of mergers and acquisitions, so home care agencies that once functioned independently of each other are now merging in order to be able to still provide for residents in their area.

There is also the challenge of workforce, so our more rural sites are also where we are most challenged to find staff and so because of that we need to pay for high-cost travel staff, as we are being reimbursed less and less but our costs to provide care are going, you know, higher and higher.

Also, we are honestly having to make difficult decisions. We have a patient that might take 2 hours to get to. We have to send a staff out to see a patient that is 2 hours away. Can we even do that when we have three other patients who are in a more tight geography? Do we go and serve that one patient or do we stay closer and serve those three? We are having to make those difficult decisions as well.

Also, with those changes, with the decrease in reimbursement, getting more creative about our workforce, so being innovative about developing our own internal workforce, so personal care assistants train to be CNAs, train to be LPNs, and so on. All of that comes at a high cost, and as we are continuing to have decreases to our reimbursement, those things were getting squeezed tighter and tighter and it is harder to do those things.

The CHAIRMAN. Thank you. I think your example of the patient who is 2 hours away is a really important one, because that is why the rural add-on is so important to compensate for that extra time on the road, rather than just not being able to serve those patients who are further away from the agency.

Mr. Hebert, Dr. Hebert, I was struck in listening to you about your comments on interdependence and also the reaction that home health workers get when they come into a person's home, because that was the experience that I have always seen when I have gone

on home health visits. In fact, I saw the senior's face literally light up when the home health nurse arrived.

Sadly, oftentimes that might be the only person who is seeing that patient, and thus can take stock of everything. Is there enough food? Are other needs being met? We held a hearing in which we learned the effect of prolonged isolation and loneliness is equivalent to smoking 15 cigarettes a day. That is how important this is.

What do you see as the biggest challenges that you are facing in trying to ensure that home health services are delivered?

Mr. HEBERT. Madam Chair, you pointed out the isolation. The research that has been done related to social isolation and loneliness make it very clear. As you said, it has a worse impact on morbidity and mortality than smoking 15 cigarettes a day, or drinking a half a dozen adult beverages. This issue of isolation is not only an issue for us here in the United States, it is an issue for aging folks across the world. We have, in the room today, guests from Europe who are here to learn from the Senate Aging Committee and some of the proactive work that you have done here.

The challenge for the rural patient in that isolation is that they do not have, in most cases, the family that my mom had, to be able to say, "Hey, look, I need some help. Come." As a result, that is often, as you indicate, the only person they may see.

As I indicated, that happens a lot here in the United States. One nurse talked about over a period of a few weeks she saw a calendar with the numbers 1 through 7 struck out. She finally had the courage to ask the patient what that was, and she said, "Well, that is my calendar." She said, "Well, tell me about it. You have only got the numbers 1 through 7." She said, "Sweetheart, when you leave today I am going to write 1 through 7 again, and I am going to mark each day off because I know that is when you are coming back."

The exact same experience I had was when I led a group of home care and hospice workers to Dharamsala, India, and spent 2 weeks in Tibetan Buddhist communities. Those people waited for their home health nurse because it might be the only visit they get in a week, so when you ask the challenges that the patient and the family has, essentially that engagement from the rural home health nurse or the home and community-based worker, those are critical for them to be able to do well. Thank you for asking.

The CHAIRMAN. Thank you. Senator Casey.

Senator CASEY. Thank you, Madam Chair. I am going to thank our witnesses for their testimony today. I will start with Mr. Adams.

Your story is a powerful story about the work that you had to do to transition from the work you had done as a steelworker. I think not only your own personal story but the reality of home care itself but also home care in the rural context is a disturbing story for the country. We are not anywhere close to meeting the obligation we have to rural seniors and their families if we do not make some changes.

As you highlighted, we have a very rural State. A lot of people do not realize that. We have got 67 counties. Some people think of my State as Philadelphia and Pittsburgh and just some towns in

between. Of the 67 counties, 48 are rural, 48. Three and a half million people live there, a bigger population than the whole State of a lot of states. I think we have, if not the top rural population in the country, it is one of the top two or three, so millions of people who have challenges that frankly exceed, often, the challenges in urban communities.

One of the points you made, Mr. Adams, is the stagnant wages, the long hours, the distance, and the difficulty of providing care in rural settings. We have got to have more resources.

You also pointed, in your written testimony, to just some numbers on turnover. When you talk about turnover in this industry, national workforce turnover rates as high as 60 percent, so if we are not recruiting more people to do this work we are not going to meet the need, and as I said, we are failing as a country. You cannot ask people to do difficult work and drive long hours if you do not pay them enough. What I am trying to do with this legislation is to focus on that basic problem, a lack of appropriate pay and a lack of investment in training.

Mr. Adams, can you just speak to that question, the question of resources that are needed to better support workers who are doing the work you are doing in rural communities?

Mr. ADAMS. Well, without the resources what it means to me is that America has failed to help the people that need them most and the people that care for them. Like the man that cuts his lights off at 7 in the evening to keep his electric bill affordable, or the lady that struggles to sit up in her bed when we feed her because she does not have a hospital bed. or the woman that waits hours for someone to drive out to her home to take her to the grocery store, because she cannot afford transportation, or the man that falls in the middle of the night because there is no home care worker there, because he does not have the funds to keep one through the night, so he lays on the floor, afraid to push his call button, because he lives outside the city, and an ambulance would cost him an exorbitant amount of money. When the home care worker comes in there in the morning they struggle to pick him up, because he is a 200-pound man, and they do not have the equipment, like a lift, to help him get back in the chair, and that is a shame.

It is important because we have 10,000 people turning 65, and these people live in their homes. Lots of times they have built those homes with their own hands. They have worked hard to pay for these homes. It means that we have failed these people, and that is a crying shame.

Senator CASEY. Thanks very much. I wanted to turn, as well, to Mr. Dombi, and I appreciate the perspective you gave us in highlighting legislation that has been on the agenda of Congress for far too long and not passed.

I mentioned the infrastructure improvements that we are trying to bring about and using target investments through Medicaid. Do you agree that these kinds of investments are necessary to expand care to home and community-based services in rural communities?

Mr. DOMBI. Senator Casey, I had the opportunity to review your bill last week for the first time and I am very impressed with it, and you can have our organization's support throughout on that.

Medicaid has proven itself to be the best place for finding home care options available to people but it is far from perfect. The turnover rates, the compensation to the workers, there still is a need for rebalancing of care.

If I find myself in need of home care there are certain states I will go to and certain states I will not go to because the distribution of support is that varied. Oregon actually is the best State among them in terms of support. Pennsylvania is doing okay, you know, and Maine is doing pretty darn good as well, but it is time that we support seniors as well as persons with disabilities with an even approach toward access to home and community-based care, and you know, it is not just about wages for the workers. It is wages, it is also career opportunities, and frankly, having been fired as a home care aide by my sister, it is about respect too. You know, these workers do the hardest job in the country. Somehow U.S. News and World Report picked personal care attendant and home care aide as the number 1 job areas to go to for people without a college education. It is a great, rewarding job, but you still have to put bread on the table.

Senator CASEY. Thanks very much, Chairman Collins.

The CHAIRMAN. Senator Hawley.

Senator HAWLEY. Thank you, Madam Chair. Thank you, Ranking Member. Thank you for holding this important hearing today about the obstacles to expanding health in rural America, and thank you to all of our witnesses. Thank you for the work that you do. Thank you for taking the time to be with us and share your perspective.

My home State of Missouri is home to a very large number of rural communities. I grew up in a rural community. I know when I talk to my constituents back at home and in these regions, one of their top concerns, if not their number 1 concern, is access to quality, affordable health care. That is all the more urgent because Missouri's population is rapidly aging. We have got a lot of seniors in the State of Missouri and a lot of them live in rural areas, so the topic of today's hearing is very, very important for my State.

Mr. Dombi, let me just start with you if I could. In your testimony, your written testimony, you discussed the innovative uses of telehealth and telehomecare, in particular, as a way to bring home health care to patient populations in communities like the one where I grew up. I am aware of the infrastructure barriers to telehealth expansion, including inadequate access to quality broadband. That, of course, places a huge restriction on health care providers in rural regions.

Despite these barriers, Congress, I know, has taken some incremental steps to expand telehealth and telemonitoring capabilities, but I think that we can probably do more. I just want to ask you, what lessons have we learned so far, in your judgment, in demonstrating the cost-effectiveness of services like telehealth, telehomecare, and what are the most promising areas, would you say, where we can utilize those services more strategically?

Mr. DOMBI. The number one gain we have seen in the use of telehealth, or we call it telehomecare, a term which someday might be adopted, but in terms of telehealth it is remote monitoring by nonphysicians as a way of keeping people from going back into the hospital, to avoid readmissions of the individual. It is important to

have boots on the ground, people to see face to face the patients, but that 24/7 monitoring of a number of patients categories has proven a high reduction in readmissions. One readmission avoided to a hospital saves tens of thousands of dollars, with very little cost attendant to it.

We have actually been working on a proposal to advance to the Centers for Medicare and Medicaid innovations to create a risk-based telehealth program, where the provider of the telehealth services would put tremendous skin in the game so that they would only be paid, or they would only be paid fully, if they demonstrated cost savings to the Medicare program, so we think that opportunity exists today out there, and it does not always need physicians, as I mentioned. These are non-physician-based remote monitoring services.

Senator HAWLEY. That is very helpful. Thank you. Do you have any recommendations for home health agencies that are looking to set up new programs?

Mr. DOMBI. Well, you know, come in with some capital, because the reimbursement systems are not yet up to date where it needs to be. That is why our proposal would have a risk-based approach to it, because, frankly, you know, when we have been working on some of these issues for over 10 years, you know, we figure we have to change the dynamic, and that is what a risk-based proposal would be about.

Senator HAWLEY. Very good. Thank you.

Ms. Howard, let me ask you, on this topic of access to telehealth services, I wonder if you could speak to your experience serving on the ground with rural communities. Older adults, we know, experience the highest rates of adverse drug events, resulting in emergency visits, and are several times more likely than younger persons to have an adverse drug event that requires emergency hospital admissions. They are also more susceptible to chronic pain, we know, and many of them are prescribed opioids to control and manage the pain.

Have you been able to leverage your program's telemonitoring technologies to identify changes in patients using opioids?

Ms. HOWARD. That is not an area that we have currently been working on, but, however, you know, having the telemonitoring in the home, of course, you know, many of our patients are on 25 or more medications and many of them, you know, are on opioids, so having that nurse checking in every day would help to be able to identify certain challenges are things that we need to followup on.

The other thing, too, that I will add about the telemonitoring is it really allows us to make those home visits on a demonstrated need, meaning we see changes in the patient's blood pressure or based on different questions that they answer, so when we talk about workforce shortages, this allows us to make those, as it is knowing when they need that visit instead of anticipating when they may need a home visit.

Senator HAWLEY. That is very helpful. Let me ask you this, my last question. Beyond expanding access to broadband, which is critically important, I think, for so many reasons, and telehealth is at the top of that list, and providing more reimbursement coverage for telehealth services, do you have any insights from your experi-

ence for us about what Congress might do to make home health care programs better, more available to more Americans?

Ms. HOWARD. One of those challenges that we have, our patients that we see are in their acute State of their disease, so maybe they have had a heart failure, readmission to the hospital, they are discharged home with our service. We are using our telemonitoring equipment during that fragile time to clue us in as to any changes that might happen that would send them back to the hospital, so we are able to take action based on those.

Currently we can only see that patient for a short period of time. Eventually we need to work to discharge, so that patient returns to that chronic health State of their heart failure, for example, and we need to remove our telemonitoring equipment, we remove the nurse, we remove the therapist or the home health aide, and that patient is now on their own, and so what usually happens is after a period of time eventually that patient may run into trouble again, and in order to access our care again they end up going to the ER, going to the hospital, and then the referral back up to home care again, and here we go out to do what we do best, to keep them out, only again for a short period of time, and we just are in that cycle.

We have been able to work with some of our Medicare Advantage plans, where we do telemonitor patients after they are discharged from their skilled home care benefit, so we telemonitor those patients for an extended period of time, sometimes make a home visit, but what we are able to do is identify those changes in the health status.

For a heart failure patient, it could be an increase in a weight or their reporting through their telemonitoring system that they are short of breath. Our nurse goes out and assesses the situation, is in contact with the physician, and many times we are able to make medication changes at that point in the home, readmit them to home care service, and then care for them again under that acute state, so we have bypassed that ER and that hospitalization visit, which would have normally brought them back to us, so we have had great success with that.

Senator HAWLEY. Very good. Thank you. Thank you for all that you do. Thank you, Madam Chair.

The CHAIRMAN. Thank you. Senator Rosen, welcome.

Senator ROSEN. Thank you, Madam Chair and Ranking Member, and I want to thank each and every one of you for being here, for everyone else who is here as well.

I know from my personal family experience as a caregiver how critically important each one of these areas are and that there are angels that walk among us, and they are the ones who help us take care of our loved ones when we can't always be there, and I am personally grateful to the angels who helped my loved ones through much of their care.

I want to talk a little bit about palliative care, Mr. Dombi. You know, based on my experience as a caregiver, I launched a bipartisan Senate Comprehensive Care Caucus. It is serving to raise the public's awareness, promote the availability, and the benefits of palliative care, and trying to find those bipartisan solutions to expand access to palliative care services, improve coordinated care, and really address issues impacting caregivers.

I am also proud to have introduced the Provider Training in Palliative Care Act with my colleague, Lisa Murkowski, Senator Murkowski, which is going to have the National Health Service Corps focus on these areas, so we know that the important work of hospice home care that providers do in their home, how can we take this hospice model, and knowing that also there are people who maybe do not need to be on hospice but they have chronic, long-term disease—cardiac disease, pulmonary disease, diabetes, Parkinson's, whatever. How can we take these palliative care, hospice care models and use them, expand them across the home health spectrum?

Mr. DOMBI. Well, thank you for that question. We are on a new frontier with palliative care. There had been a struggle at one time for people to even recognize it as a necessary service for individuals. My sister was fighting stage IV breast cancer, and her oncologist was hell-bent on killing her cancer. At the same time she was having a miserable life and so we brought in a palliative care physician to support her. The oncologist, then, and the palliative care physician were butting heads for a number of weeks until they realized they needed to be in partnership.

My sister did not make it through her breast cancer, but palliative care is not just end-of-life services. It is an important component to end-of-life but palliative care truly is something that should be part of all health care services, at all times.

I think, you know, when I say we are at a new frontier, we are at the new frontier of awareness. I do not know if all the solutions are out there yet. Probably not, but when we look at the solutions we start with the recognition that, while I mentioned the physician in palliative care, much of palliative care is provided by non-physicians—nurse practitioners, nurses, personal care aides. It involves much more than even clinical health care kinds of services.

One of the recommendations that we have been making is that you can take existing benefit structure, in Medicare, for example, like the home health benefit, and make it a palliative care component to it without honestly having to go through Congress to do so. It is skilled care. It is care for people who are, you know, in their homes. It can be done by the professionals with the home health agencies, if they have some specialized training, and we do not see it as really increasing spending much in any way, if at all.

At the same time, in a pre-hospice kind of mode, there are some efforts to try to experiment with what we would call pre-hospice palliative care. We are seeing it in the managed care context, but more than half of the country is not in a Medicare managed care program. I hate to admit but I am a Medicare enrollee, and I am not in Medicare Advantage at this point. I do not know if I ever will be, but we need to experiment also within the fee-for-service kind of program.

An example of where to go might be Medicaid, where they have used dollars in a very flexible kind of a person. Ranking Member Casey, you have support for money follows the person within your bill. Similar concepts relative to using the dollars that would otherwise go into higher cost settings, into palliative care, I think is a good option for us to consider, in both Medicare and Medicaid.

Senator ROSEN. Now I have to agree with you, especially as we talk about the mental health, the depression. All those things really—you're going, what is in the refrigerator?—all these things matter to the care and consideration and overall health of a person, and contribute to them going up or going down. If you would like to say a few words, please.

Mr. HEBERT. Senator Rosen, I really appreciate that question. One of the things that a lot of public health folks chuckle about today is the change in names and how people are excited that we have this new issue of social determinates of health, when public health folks know that these are issues they have been addressing for decades.

Palliative care is care that has been provided by home health workers for decades, and it is now beginning to be recognized that we have got people like the ones you just questioned, who have multiple comorbidities, multiple chronic illnesses, and to be able to manage those well, palliative care benefits could significantly change things.

You talked about the Training Act. One of the things that is critical to this conversation is workforce, so not only training for workforce but our medical schools, nursing schools, social work, therapy, et cetera, have been educating people for many, many decades, based on an acute care model that is very hospital-centric, and I would add physician-centric, so one of the challenges that we have is to change curricula across all of those schools, to include rural components of care at home and certainly palliative care.

Thank you for that very important question.

Senator ROSEN. Thank you for being here today.

The CHAIRMAN. Thank you very much, Senator.

Senator Braun, welcome.

Senator BRAUN. Thank you, Madam Chair. I just got here a moment ago, but everyone, I think, knows here, since I have been here about a year, that health care is the thing that I think is most urgent, and that in my own business many years ago I really worked hard to make it consumer driven and transparent. I know the particular arena you are in. Indiana, I think, would be in the category of where we have not done well with home care.

I would like to know, whoever might be able to give me an answer, where it has a foothold, what is the financial difference between home care when it is working at its best versus traditional, which we have mostly in the State of Indiana, which would be through a nursing home?

Mr. DOMBI. I can try that question. I think it is working really well in place like Oregon and Washington State. New York State, a long time ago, had a policy of directing people to kind of a home care first approach, keeping people out of long stays in hospitals because no nursing home beds were even available for those individuals.

There have also been several studies, including from New York, indicating that the woodwork effect does not happen, the woodwork effect meaning that if you make it available, people who are currently not costing anything to the system will go to that service, and, in fact, that has not been the case.

Where it is working best as well is where there is support, as Dr. Hebert referenced, with the informal caregivers, because the bulk of home care services is provided by family and friends. I think AARP recently estimated it to exceed $570 billion a year, whereas total home care spending in the business of home care is about $125-$130 billion a year. The VA has done pretty well in connecting caregivers in the informal sense with paid caregivers for respite services and otherwise, so when we were looking to where it is working best, we are looking to those kinds of states in the upper Northwest, we are looking to New York, and we are looking to some of the other government programs. The VA has the most robust home care program of any program on paper. I had the privilege, I hope, this afternoon I am testifying at the House Veterans' Affairs Committee about home care services. It is great on paper. It needs a little bit of improvement in practice, though, but it still provides a lot of guidance.

Senator BRAUN. What were the catalysts that worked for Washington, Oregon, New York, or even the VA, to kind of push home health care, and how much entrepreneurial energy has there been? My main beef with the health care industry in total is that it has lacked transparency, it is inherently uncompetitive, it has barriers to entry, and the consumer is not engaged, to boot. When you take two of those four, you generally do not have a well-functioning supply and demand, you know, market that drives, generally, prices low in other markets, and then you differentiate by your intangibles, so when it comes to, what was the original catalyst—let's just take Oregon or Washington or the VA—that got it to where it has pushed something that seems to be a better value, you know, for the customer?

Mr. DOMBI. It was looking for value. It was looking to control spending, in Medicaid as well as in the VA. Secondarily to that, but very much equally important, is the humanity aspect of giving people the opportunity to stay at home but the driver was the bottom line.

With the growing population of need for long-term services and supports, the population being served, whether it was in the VA or in the Medicaid program, which is a primary funding source for long-term care, the recognition was they had to find a better way than the high cost of caring for individuals in nursing homes, combined with the concern that nobody wanted to go to a nursing home and that is what really drove it.

There is tremendous competition in home care in a number of the sectors that are out there. It is an unusual economic dynamic, marketplace dynamic. You have mom-and-pop operations working at farmhouse in Appalachia and you have public companies that operate in 40, 50 states nationwide.

Senator BRAUN. That is refreshing, because it is normally not the case through any other parts of health care, and then do you run into, within certain states, where the nursing home industry—in other words, the status quo that has been around a long time, that is there—not giving you that good deal, that has weighed in to kind of suppress what looks to be some grassroots competition? Is that something that occurs?

Mr. DOMBI. Yes. I am going to give you a delicate answer there.

Senator BRAUN. I figured it would be.

Mr. DOMBI. We tried to work with the nursing home world as well, but you can go to every State legislature and they all know their nursing home operators. You know, it is harder to get to know the home care operators, and it is very hard to get to know the home care workers because, you know, they gather at the person's home rather than at a facility somewhere.

Senator BRAUN. Well put, and I think that is our goal as Senators, to provide, where it normally occurs, when you have transparency, when you do not have a strong lobby that tries to suppress that stuff. It works so well in other places. It is good to see that in home health care that it is actually succeeding in a system that is basically dysfunctional and broken.

Mr. ADAMS. If I may add, the states that he mentioned all have good unions, good wages for home care workers, and that is part of the reason why those states function well. Their wages are reasonable, the union is strong, and as he stated, the states are doing well.

Senator BRAUN. That is good to know as well, and that makes sense. It is good to see that it also engendering higher wages for that function.

Did you have——

Mr. HEBERT. Senator, I would add that value-based purchasing has had an impact. Even though it is slow and moving along, we are moving away from the old sick-care model where everything is fee-for-service and reimbursement is based on volume, so the move toward value is critical in the home care space as well, and I think that is why you have seen that sort of progressive activity in the states that you mentioned.

Senator BRAUN. Thank you for setting a good example. I hope the rest of the industry is paying attention. Thank you.

The CHAIRMAN. Thank you very much. Senator Sinema.

Senator SINEMA. Well, thank you, Chairman Collins, Thank you, Ranking Member Casey, and thank you to all of our witnesses for being here today.

As seniors live longer they should be able to access home and community-based services wherever they live. I believe we must do more to help seniors live safely at home before they need to receive specialized medical care at home or in a residential facility. A part of this effort includes increasing access to home care and assistance with daily activities, such as bathing, eating, dressing, or even ensuring medication adherence.

This week I was proud to team up with Senator Cory Gardner of Colorado to introduce the Home Care For Seniors Act. Our common-sense, bipartisan bill allows seniors to use their tax-advantaged health savings accounts to pay for home care. This will help seniors remain safely at home and provide needed relief for family caregivers. We think it is a first good step but we must do more.

As I have heard from Arizona's local Area Agencies on Aging, home health care remains an acute challenge for rural communities and seniors, so this leads to my first question for Mr. Dombi, although I welcome everyone's thoughts.

Arizona's Medicaid program is pursuing exciting collaborations to build a long-term care workforce, especially in our rural commu-

nities. Working with technical high schools, community colleges, and nursing programs, this initiative will develop training courses that help students quickly earn a license or certification and enter the home care workforce. There are also options for students to continue on to a licensed practical nursing program or other advanced jobs in the health care industry. The goal is to help increase career mobility in rural areas while managing the training and hiring costs that can be prohibitive for our rural providers, particularly those who need entry-level direct care workers now, so do you believe that such a strategic plan could be implemented on a larger or national scale to help address the short-term need we all face for a qualified workforce?

Mr. DOMBI. We need a multidimensional strategy to improve the availability of the workforce within home care, and your proposal has many of the elements that are absolutely worth employing in that. When we look at the kind of strategies that have been employed, they have had a little bit of impact so far, but when we look at particularly the personal care services supports for activities of daily living and the workforce that provides those services, it implicates a broad array of elements within our health care delivery system. Compensation is absolutely one of them.

Figuratively, I think the State Medicaid programs combined make up the largest employer, figurative employer, of the low-wage workers across the country. You cannot pay somebody a living wage if you are paying $12 an hour for the services to the employer. You could not give $12 an hour to the worker because you are paying things like your taxes and, you know, your rent, and paying for the billing and such.

It goes beyond compensation. It goes into other elements, like a career ladder opportunity for the individuals who wish to be there. Flexibility may be necessary, even in some of the Federal wage and hour law to deal with the issue of scheduling of these workers, that the workers do not necessarily schedule their time based on their interests. They schedule based on upon the clients' interests, and they work well to do so but it doesn't necessarily fit with the existing wage and hour law when calculating such issues as overtime compensation.

Immigration fits into the issue as well, you know. We know that is a very sensitive issue in this country today, but when you are looking at the workforce that is out there, a quarter of the current workforce providing for personal care supports are recent immigrants.

If we look back perhaps on our own family history, my grandparents came from Hungary, Lithuania, and Poland in the late 1800's, and they took, as most immigrants do, the hardest, lowest-paying jobs that are out there. They worked with trying to advance their families along the way. We do have to take a look at our immigration policies to see, can we bring that kind of workforce to bear?

The demographics of our country, in many ways, will require us to bring in new people. I had four people—children in my parents' family that could help care for them as they aged. I have two children. Not only am I not liked by them, but they cut my resources in half, so somewhere I am going to have to find outside caregivers

when that need might arise, but I appreciate, really, the work that you are doing to explore these various things. There is no one silver bullet solution.

Senator SINEMA. Yes. Thank you so much.

Mr. HEBERT. If I could add——

Senator SINEMA. Yes.

Mr. HEBERT [continuing]. Senator, it is a very important question. I think that one of the things that we need to find a way to do—and, Madam Chair, I am going to borrow a term from a couple of your PhD public health folks in Maine-—it is important for us to find incentives to keep our free-range, pass-the-raise children at home. If we can keep those rural people in there and give them incentives, they already know the culture, they know the climate, they know the people, so part of our challenge is to find those folks at home and provide incentives.

Thanks for your good work.

Senator SINEMA. Thank you. Thank you, Madam Chair. My time has expired.

The CHAIRMAN. Thank you. Mr. Dombi, as you know, we have worked together for years to allow nurse practitioners, physician assistants, other advanced practice nurses to prescribe home health care, and oftentimes, as I pointed out earlier, they are the primary care provider for the person needing home health care.

One nurse practitioner expressed to me her frustration that she could prescribe, she could order x-rays, can do all sorts of tests, and yet she cannot prescribe home health care for her patient, her very own patient who is being discharged from the hospital, for example.

I just do not understand the resistance to allowing more health care providers to authorize home health care. What is the chief criticism of expanding those who can prescribe home health care, and what is your response to that criticism?

Mr. DOMBI. The roadblock is not at the State level. States have authorized these practitioners to order home health services, to manage patients in the home care setting, to varying degrees, either, you know, completely independent or in some collaborative relationship.

The barrier is an antiquated Medicare program, and I think the barrier is still there simply because there is, at one time, concern on program integrity and concern on quality of care, which was not well founded in the first place. Instead, as my written testimony points out, we think program integrity is compromised and quality of care likewise compromised with this antiquated rule, when you have to hand off to a physician.

There is one other factor that has come into the mix over the years, as we have tried to get this legislation passed, and that is the Congressional Budget Office. We still do not have a score, a formal score, from CBO on this. CBO at one point gave us an informal score, gave the House—I say us—gave all of the stakeholders an informal score of what they called budget dust, under $100 million, something close to my annual salary, you know, budget dust, and then, suddenly, the Centers for Medicare and Medicaid Services stepped in and advised the CBO that they had concerns on program integrity as well as quality of care. My information is now

that CMS no longer holds those views, but we still need a CBO score in order for this to move forward. We think this really should be scored as a saver rather than as a coster there.

I do not think there is anybody who is, you know, categorically opposing it. More and more physician groups, who one time might have been considered competitors, are now coming on board because they are partnering in so many different ways, business wise as well as caring for patients, with nurse practitioners, physician assistants, and the like.

Mr. HEBERT. Madam Chair?

The CHAIRMAN. Yes, Dr. Hebert.

Mr. HEBERT. Madam Chair, I would offer this is even more critical in rural areas——

The CHAIRMAN. Yes.

Mr. HEBERT [continuing]. where the primary care practitioner is a nurse practitioner or a PA, so this is a vital issue for rural communities. Thank you.

The CHAIRMAN. Thank you.

Mr. HEBERT. Thank you for your long-term support of this issue.

The CHAIRMAN. I completely agree with your comments, and it is one reason that I have felt so frustrated that we cannot get this common-sense change made, that is going to improve the lives of patients and prevent rehospitalizations or worsening of their condition because of the delays that are often inherent in finding a physician to authorize the care. It just makes no sense and I am going to work on trying to get the CBO to give us a score and see if we can enlist the Financial Committee leaders to help us in that regard. I personally believe that it is going to save money, for a whole host of reasons, and we could use that.

Mr. Adams, I saw that you were nodding when Mr. Dombi was talking about the VA doing a good job. Did you have anything you wanted to add on that topic? If I could ask you to turn on your mic. Thank you.

Mr. ADAMS. The thing that I was nodding my head about is the fact that he mentioned Washington State and New York. These are places that have strong unions, and the unions are the people that advocated for the safe working conditions, that advocated for the higher pay. When you advocate and you have higher pay and better training, it attracts people to the jobs. That is why those states are successful, and that is what we are trying to do in western Pennsylvania.

The CHAIRMAN. Thank you. Finally, Ms. Howard, I want to commend you for being such a leader in telemedicine, telemonitoring, because that can be so helpful, especially if you are servicing someone who lives on an island off Maine, where it is very difficult to get to them. That was an example that you had used.

I have noticed that when I am talking to veterans who have come back, who have post-traumatic stress, that they actually really like the telemedicine, the younger veterans in particular. They prefer it to having to go to the office of a psychiatrist or a therapist or a mental health counselor, so there are two questions I have and that is, are your older patients receptive to telemedicine, first of all, and second, what roadblocks do you see to expanding telemedicine?

Ms. HOWARD. Thank you for those questions and thank you for your recognition of our program. I appreciate that, so some of the roadblocks to expanding, of course, are broadband and cell connectivity. A patient does not need to have Wi-Fi or internet at home. If we can get a cell signal at that patient's home we can still transmit the data, and that helps us tremendously to be able to get the information that we need. You do not have to stray too far off I–95 to start to run into complications, especially with a cell signal, and of course the coastal areas is also a challenge.

Our seniors, they enjoy using the equipment. It is very simple. It is a tablet-based system, and it walks them through it. They enjoy it, which is a surprise to some people. They would think they would not be accepting to the technology in their home, but we have learned not to assume, because many of them are probably more tech savvy than some of us, which is great, so, you know, and the other thing is, you know, as we look to expand, the challenge is that, you know, yes, it is under our episodic payment, but our providing this benefit, we have to afford that financially through grants, through cutting in other areas because as we have had more and more cuts, you know, in looking for where can you cut back, and, you know, as you cut more and more in our operations budget and then that means we are not as able to utilize as much equipment with as many patients as we would like to, because we cannot afford to purchase more equipment.

The CHAIRMAN. Thank you. Senator Casey.

Senator CASEY. Thanks very much. I will pick up on the last answer by Ms. Howard, referencing broadband. One of the many problems that still burden rural America, for lots of reason—health care, broadband is a problem for health care, it is a problem for business. It is another way that we shortchange rural America. Health care itself, when we have got proposals in this town all the time to cut Medicaid, for example, it disproportionately falls on rural America when that happens.

We know that more kids, as a percentage, in rural America, depend on Medicaid and CHIP than even in urban areas, because in urban areas you have low-income folks. We have higher-income folks that do not depend upon—who live in cities but do not depend on CHIP and Medicaid, so Medicaid is a program that is so critical to rural America.

We have a proposal now by the Administration to allow states to cap Medicaid spending for certain populations. I am reading here from an Associated Press story, February 6th. The first sentence of the article is very simple. It says, "Governors of both major political parties are warning that a little-noticed regulation proposed by the President's administration could lead to big cuts in Medicaid, reducing access to health care for low-income Americans." That is Governors of both parties saying that about the adverse impact on low-income folks through this just one proposal on Medicaid. When you combined that with the proposed cuts in the budget announced this week, once again we are talking about rural America paying the freight, dealing with the impact of Medicaid cuts.

There are some people who walk around this town morning, noon, and night, talking about how much they care about rural America, and then they propose these cuts to Medicaid, so we know

what the Governors of both political parties say about it. We know what health care experts say about it. Mr. Adams, I am just going to ask you. You are in the trenches. You deliver home health care to rural communities. Tell us what you think the impact would be on your work and the people you take care of in rural Pennsylvania, with these cuts.

Mr. ADAMS. These cuts, as I stated earlier, would be devastating to the community, people that have no transportation, and as I stated they would have no ambulances. It would be harder for those of us who have low wages to afford gas to get to work. They would not have food to eat.

Senator CASEY. What the Federal Government is asking the states to do is to stretch their Medicaid dollars much further and as our Secretary of Human Services said, "Permitting states to grow—if this happens it would permit states to grow health inequities experienced by the poorest Americans." That is rural America.

Chairman Collins, thank you very much.

The CHAIRMAN. Thank you, Senator. I want to thank all of our witnesses for their contributions to our hearing this morning. It was an excellent panel.

I also want to point out that we had a number of Senators who dropped by who were unable to stay due to conflicts in their schedule, but I did want to read their names for the record: Senator Rick Scott, Senator Gillibrand, Senator Jones, with whom I have a bill to expand rural broadband, and Senator Blumenthal were all here. I very much appreciate that and know that they would have liked to have stayed.

I also want to recognize Lisa Harvey-McPherson, who is here. I have worked with her for literally probably two decades on home health care issues. She was one of the people who first introduced me to the topic and sparked my great commitment to home health care.

Home health care is clearly a compassionate and less-expensive way to care for our seniors, for our disabled citizens, and for others who need assistance. It is far less expensive than hospitalization or going to a long-term care facility. It allows our seniors and disabled citizens to be at home, and that is where they overwhelmingly want to be.

Of an estimated 73 million baby boomers in America, roughly 10,000 of them turn 65 years old each day. That combined with the increasing life expectancy rate illustrate the need for us to ensure that we get ahead of this issue and that we ensure that we have the workforce, that we have the technology, that we have the reimbursements across all of the programs that are affected in place for caring for this generation, and that we not wait until we have a crisis, which I think we are approaching when it comes to workforce issues, to deal with these issues.

As home health care has become even more skilled over the years its promise has grown, and we must do everything we can to not only keep the doors open for home health agencies but to help them thrive so that they can serve those rural patients. The two home health care bills that I have introduced have received wide bipartisan support, and I look forward to shepherding them across the finish line.

Again, I want to thank our witnesses and Committee members for their dedication to the cause, and I also want to thank our staff for their hard work too.

I now will turn to Senator Casey if he has any further closing remarks that he wants to make.

Senator CASEY. Chairman Collins, thank you for the hearing. I want to thank our witnesses for providing great insight into these issues. I will just be really brief and say we have to provide much more help for the people doing this work, and we have to prioritize the health care needs of rural Americans. We are not doing that nearly well enough. One of the best places to validate that we care deeply about the people who live in those communities is to make sure we do not cut existing services that are provided through programs, especially those like Medicaid.

Thank you, Madam Chair.

The CHAIRMAN. Thank you. Committee members will have until Friday, February 21st, to submit questions for the record. If we get additional questions we will be sending them your way.

Again thank you, and our timing is exquisite because the vote has just begun. This concludes our hearing.

[Whereupon, at 10:37 a.m., the Committee was adjourned.]

# APPENDIX

## Prepared Witness Statements

# Northern Light Home Care and Hospice

## Special Committee on Aging
## United State Senate

## "There's No Place Like Home: Home Health Care in Rural America "

## February 12, 2020

## STATEMENT FOR THE RECORD


## Leigh Ann Howard RN, DNP, CHKN-K
## Director of Home Health and Specialty Programs


Chairman Collins, Ranking Member Casey and members of the United States Senate Special Committee on Aging.

Good morning, My name is Leigh Ann Howard and I thank you for the opportunity to speak before you today to share our experience as a provider of home health care in rural America. I currently serve as the Director of Home Health and Specialty Programs at Northern Light Home Care and Hospice, a Medicare certified home care and hospice agency. As a member of Northern Light Health, a Maine based statewide integrated health care system, our home care and hospice programs serve patients throughout the entire state of Maine. Maine citizens are

among the oldest in the country living in a state with a large rural geography. Over the last year Northern Light Home Care and Hospice clinicians drove over three million miles to provide care, making close to 200,000 home care and hospice home visits. At times the transportation to get to a patient's home is just as unique as the geography of the state of Maine. For example, to serve many of the island communities off the coast of Maine, we travel by lobster boat or mail boat as this is the only way to reach the patient. This time of year, our staff may have to shovel their way down a long driveway of snow to reach the front door. Traveling the winding back country roads in the unpredictable weather conditions of western Maine also brings another layer of challenge. The travel time between some patients can be more than an hour.

As the Maine's rural population continues to decline, so do the number of qualified health care professionals. Healthcare workforce shortages have reached critical levels. Maine is experiencing a current and expanding shortage of nurses expected to reach 2700 registered nurses by 2025. In the rural regions we serve, nurses are among the oldest professionals in the State of Maine. Later in my testimony I will brief you on how we utilize technology to support the care provided by our home care nurses. Unfortunately, nurses are not the only health care profession experiencing a workforce challenge, some rural areas have a shortage of physicians leaving nurse practitioners as the only primary care professionals in the area. This creates significant barriers for rural residents needing to access home health care. Federal law prohibits nurse practitioners, and physician assistants, from ordering and certifying services for Medicare home health care. This barrier has a multiplier effect as Medicare Advantage plans and MaineCare (Maine's Medicaid program) enforce the same standard. We know that Nurse Practitioners are safe and effective in ordering home care services as evidenced by commercial carrier coverage in Maine. The best example of this challenge is a patient example. We recently

received a referral for home health care from a nurse practitioner for a patient discharged from a small rural critical access hospital. The patient needed home based nursing and physical therapy services to continue recovery at home. Our home health organization and the patient's nurse practitioner worked for weeks to try and identify a physician who would agree to sign the home care orders. This delay created a significant barrier for the patient to be able to access the home health care needed to help aid in his recovery. In our experience, patients have been readmitted to the hospital before a physician could be located to sign for home health services. These patients were all receiving their primary care from nurse practitioners.

Unfortunately, these situations are repeated all too often. We know that delays in receiving home health services post discharge from the hospital significantly increase the patient's risk of being readmitted to the hospital, often due to falling at home or medication errors. Rural patients already face significant changes accessing care due to lack of providers as they live in regions with no public transportation and experience significant travel required to get to a provider's office. Removing barriers and creating access to health care for our rural residents is essential to realize improved health outcomes for everyone regardless of where they live.

With the recent changes in Medicare home health brought by PDGM (Patient Driven Groupings Model) the importance of collaboration between home care clinicians is more important than ever. We are focused on how technology can support our staff to be efficient in the delivery of clinical services that support our patients to achieve individualized clinical goals.

Supporting this focus, we have had significant success using remote patient monitoring with our rural home health patients. Remote patient monitoring is a service that places technology monitoring devices in the patient home with remote monitoring of the clinical

information by a RN working through a secure web-based portal. The technology also includes patient education modules that we can customize to align with the home health plan of care. Patients who are high risk for rehospitalization use telemonitoring equipment that checks weight, blood pressure and heart rate. The readings are then sent via cell signal or the patient's internet to our web-based portal. The telemonitoring nurses review the readings every day. The nurses reviewing the readings are certified in heart failure through a national certifying body and can take quick action depending on the readings. Based on the patient's readings the nurse may call the doctor or use a medication-based protocol to manage the patient's symptoms in the home. Every time the patient's telemonitoring readings demonstrate a need to activate the medication-based protocol qualifies as an avoided ER visit. Throughout this process we are working in collaboration with the patient's physician. If an office visit is needed the visit can be made and transportation coordinated. The telemonitoring program has realized a monthly hospitalization rate between two to four percent, compared to a national benchmark of 24.9% 30-day readmission rate. This program also allows the home care nurses to make home visits based on a demonstrated need as opposed to an anticipated need, very important given the shortage of nurses. Currently we are tele-monitoring over 300 patients state wide every day.

Knowing that the best stories are patient stories, one of our biggest successes is a patient who had over 20 ER visits and hospitalizations with in six months. Once admitted to home care and telemonitoring we worked with the physician to design a medication-based protocol that would meet her unique needs. Her ER visits and hospitalizations were significantly decreased, and she has been able to stay at home for more than five years.

Telemonitoring services are not reimbursed by Medicare but it is allowable in the episodic home health plan. It is unfortunate that as we are successful keeping the patient out of

the ER and hospital, we must progress to discharge the patient from home health services. This also results in the telemonitoring equipment being removed from the home. This is unfortunate as the simple act of the patient using the telemonitoring equipment could continue to keep the patient successful at home. By continuing the use of the telemonitoring equipment the home health staff may identify symptoms early and notify the patients physician for intervention. Early identification of symptoms could help the patient avoid the ER or hospital.

We have also expanded access to telemonitoring technology to individuals at elderly housing locations and senior socialization locations. Individuals do not need to be in our formal home care program, they register to participate and receive an identification card that they use to activate the system and their clinical data is transmitted to our web-based portal. Telehealth nurses evaluate the data for risk and contact the individual to recommend follow up with a health care provider.

While we are successful in the use of technology to support home care, we also know that many of the electronic tools that help facilitate care collaboration are difficult to use due to low connectivity in our rural state. Many areas have little to no cell phone signal. Broadband is difficult to come by and the cost is above what they could afford. When we experience this challenge, patients call in the clinical data to the telemonitoring nurse and we manually enter the information into the web portal so they can benefit from the program. The telemonitoring equipment also has capability for video visits. This is not something we have been able to utilize to its full potential due to the broadband challenges.

As a certified Medicare home health agency, we know the clinical benefit our patients experience when receiving care at home, we also know the limitations of the program as it is designed today. Medications have a significant role in the health and wellness of our patients.

Many of our patients have medications in the home that were previously prescribed but are no longer needed, previously prescribed but with a new dose and medications that are new to the patient post hospital discharge. Home care nurses routinely reconcile all the medications into a clinically accurate list of medications for the patient. But, in some situations the medication regime is so complex that the patient, home care nurse, and provider would benefit from an in-home pharmacist consultation for polypharmacy management. Home pharmacist visits are not part of the skilled services in the Medicare home health benefit. We also experience the challenge that occurs when patients have completed the skilled component of their home health plan of care and are discharged in need of ongoing support for pre-filled medication boxes. Patients often rely upon family or friends to assist but in rural areas many patients are isolated without this type of support. A home health aide could be provided with training on medications to perform the med box pre-fill service for patients who are on a maintenance schedule of medications, unfortunately this is not part of the Medicare home health benefit as it exists today.

In closing I am honored to be here today sharing the important work of our home care and hospice staff and the clinical benefit provided to the patients we serve. Thank you once again for this opportunity.


Mary Myers, MS, RN
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**TESTIMONY OF WILLIAM A. DOMBI, PRESIDENT**
**NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE**

**Submitted for the Record at a Hearing on**

**No Place Like Home: Home Health Care in Rural America**

**Before the**
**SPECIAL COMMITTEE ON AGING**
**February 12, 2020**

**For additional information please contact: NAHC Government Affairs 202-547-7424**

Since 1982, the National Association for Home Care & Hospice (NAHC) has been the leading association representing the interests of home health, hospice, and home care providers across the nation, including home caregiving staff and the patients and families they serve. Our members are providers of all sizes and types -- from small rural agencies to large national companies -- and include government-based providers, nonprofit voluntary agencies, privately-owned companies and public corporations. The provision of high-quality, life-enhancing care to vulnerable individuals and education and support to their loved ones is central to our collective purpose. We welcome the opportunity to submit testimony for the record for a hearing before the Senate Select Committee on Aging on "No Place Like Home: Home Health Care in Rural America," and to provide our views on key issues related to home health care.

## MEDICARE HOME HEALTH SERVICES

**Background**

Since the beginning of Medicare, the home health care benefit has had a special place in the package of services available for coverage by Medicare. It is the only benefit that is available under both Medicare Part A and Part B. 42 U.S.C. 1395d(a)(2); 1395k(a)(2)(A). Early into the Medicare program, Congress saw the wisdom of removing barriers to utilizing home health services, including the elimination of any required cost sharing for Medicare beneficiaries in 1972. 42 U.S.C. 1395l(a)(2); 1395l(b)(2). The benefit covers a wide range of services and supplies, including skilled nursing care, physical therapy, speech-language pathology, occupational therapy, medical social services, and home health aide care. The home health services benefit has no durational or visit volume limit.

It is also a benefit that is available to those beneficiaries who meet the "confined to home" and "skilled care" requirements regardless as to whether the patient has acute, post-acute, chronic, or end of life care needs. Overall, it is a fairly comprehensive home care focused benefit that is not dependent on a pre-institutional care requirement, as well as one that helps avoid the use of costly institutional care.

Notably, the Medicare home health benefit is well managed. Spending on home health services has been relatively stable with 2011 spending at $18.4B and 2017 spending at $17.8B. Utilization levels are also stable with 3.42 million users in 2011 and 3.39 million in 2017. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics. The lack of growth actually is surprising given the nationwide shift towards care in the home and away from inpatient and institutional care.

Today, home health services is the backbone of successes in innovative care delivery programs whether in a bundled payment program of post-acute services, as part of the services managed in an Accountable Care Organization, the Independence at Home demonstration program, or programs focused on specific care needs such as the risk-based reimbursement for joint replacements.

Still, there is room to modernize the Medicare home health benefit and improve the range of services available to Medicare beneficiaries. For purposes of this testimony, we will focus on five areas of important reforms that would directly impact on care access in rural areas. At the

same time, these reforms can bring added support for the access to and delivery of home health services throughout the country.

**Home Health Care Planning Improvement Act S. 296/H.R. 2150**

**Background**

Since 1965, Medicare law requires that a physician certify a patient's eligibility for coverage of home health services. Many things have changed in health care since this Medicare provision was enacted. Much of primary care provided today comes from highly skilled non-physician practitioners such as Nurse Practitioners, Physician Assistants, and Clinical Nurse Specialists. As a result, these professionals must "hand-off" their patients to a physician simply to comply with outdated Medicare certification requirements. Similar legislation allowing Non-Physician Practitioners (NPPs) to certify a patient's eligibility has been introduced in past Congresses beginning in 2007, garnering strong broad bipartisan support in each session of Congress. In the 115th Congress, 46 Senators and 182 Representatives cosponsored the legislation. Currently, there are 43 Senators and 134 Representatives as cosponsors including the Chair and Ranking member of the Senate Special Committee on Aging.

Today, this legislation is supported by numerous patient advocacy groups, health care professionals, and physician groups as well. There is an obvious reason why there has been such widespread support—our nation depends on non-physician practitioners every day to provide primary care to people of all ages as the availability of physician practitioners diminishes. Across, the country, the states have established a scope of practice authorization that permits these practitioners to order and manage home health services.

As of 2016, Nurse Practitioners, just one of the sectors of non-physician practitioners, comprised 25.2% of providers in primary practices in rural areas and 23% in non-rural areas, having grown from 17.6% and 15.9% in 2008.

Outside of home health services, Medicare recognizes the value and competence of non-physician practitioners. For example, in 2017 Medicare paid for 31 million in office visits by Advanced Practice Registered Nurses and Physician Assistants. Barnes, et al, "Rural and Nondual Primary Care Physician Practices Increasingly Rely on Nurse Practitioners," Health Affairs, June 2018. Over the same period, the number of E&M office visits billed by primary care physicians decreased by 16 percent. http://medpac.gov/docs/default-ource/reports/jun19_ch5_medpac_reporttocongress_sec.pdf?sfvrsn=0 The Medicare Payment Advisory Commission (MedPAC) also notes that in 2017, 34% of Medicare beneficiaries received a billable service from a Nurse Practitioner, up from 16% in 2010.

Similarly, the Journal of the American Medical Association (JAMA) indicates:

> "This analysis demonstrated a narrowing gap between primary care NP and physician workforce supply over time, particularly in low-income and rural areas. These areas have higher demand for primary care clinicians and larger disparities in access to care. The growing NP supply in these areas is offsetting low physician supply and thus may increase primary care capacity in underserved communities."
> https://jamanetwork.com/journals/jama/fullarticle/2720014?resultClick=1

It is notable, that Congress amended Medicare law in 1997 to permit non-physician practitioners to certify Medicare benefit eligibility for the skilled nursing facility benefit. 42 U.S.C. 1395f(a). The Centers for Medicare and Medicaid Services (CMS) itself recognized the value and need for non-physician practitioners in home health services by permitting NPPs to conduct the required face-to-face patient encounter that was instituted in 2010.

Medicare is not alone in the expanding use of NPPs. Recently, the VA health system expanded the use of NPPs in all of its facilities. In addition, a recent Executive Order set out the Administration's overall policy of removing federal government-based barriers that prevent health care professional, e.g. NPPS, from practicing at their highest level possible for their profession. https://www.whitehouse.gov/presidential-actions/executive-order-protecting-improving-medicare-nations-seniors/

It is now time to pass S.296 and bring this long overdue modernization of the home health benefit requirements into reality. In 2007, when such legislation was originally introduced, the reform may have been considered an innovation, Today, it is a necessity.

S. 296 would:

- Allow Non-Physician Providers (NPPs) to certify a patient's eligibility for the Medicare Home Health Benefit.
- Permit NPPs to establish and manage the patient's Plan of Care provided it is within the scope of their practice under state law.
- Enable NPPs eligibility to certify the face-to-face encounter requirement.

Here are just some of the barriers to care and inefficiencies that would be addressed with the bill:

**Improve Program Integrity**

Current physician-focused certification requirements force patients to shift from their primary care practitioner to a physician who has not cared for the patient. In addition, there is a risk that program integrity is compromised when the patient is "handed-off" to a physician for the sole purpose of meeting Medicare certification requirements. The existing standard requires that a physician certify the patient's eligibility for Medicare benefits even though the NPP is likely to have a far greater understanding of the patient's condition and needs

relative to benefit eligibility standards. Permitting NPPs to certify Medicare eligibility enhances Medicare safeguards in the Home Health Benefit as the certification is done by the practitioner that actually cares for the patient.

**Quality of Care**

NPPs can improve the transitions of care of patients to community-based care, potentially resulting in a decrease in the length-of-stay at hospitals and skilled nursing facilities because it would no longer be necessary to insert a physician who has not cared for the patient into the process. Importantly, it should not increase Medicare home health spending as NPPs would just continue their care of patients and not require the substitution of a physician to complete the certification. A "hand off" to a physician runs the risk of miscommunications and documentation errors as more health care personnel are involved with the patient. This is especially relevant where the physician is not the patient's primary care professional and may barely know the intricacies of the patient's care needs.

**Cost Savings**

Medicare would reduce spending if NPPs were authorized to certify home health benefit eligibility and establish a patient's care plan as the reimbursement rates for NPPs are less than payment rates for MDs. More importantly, paperwork costs would be reduced as it would no longer be necessary that the primary care practitioner, the NPP, would need to pass the patient over to a physician who would need to compose duplicative paperwork.

Ultimately, S. 296 should be viewed as a long overdue modernization of the Medicare home health benefit. Any program integrity or quality of care concerns existing in 1965 are no longer relevant as non-physician practitioners are not only key players in today's health care delivery, particularly in community-based care and rural areas, but it has been demonstrated countless times in other Medicare health care sectors that such modernization brings great value to both patients and Medicare. It is time to bring the home health benefit into the 21st century too.

**Reinstate the Medicare Home Health Rural Add On**

**Background**

The longstanding Medicare rural add-on for home health services will be phased out completely by 2022, threatening the provision of the home health benefit in rural areas. Since the 1990s, the home health services payment system has recognized the special needs of rural areas as there are high travel times, travel costs, and often the need for extended duration of the service visits.

The Bipartisan Budget Act of 2018 extended the 3% rural add-on while also scheduling a phase-out and an add-om differential targeted to certain rural areas. Section 50208(a)(1) of BBA. CMS implemented the BBA requirements in a manner such that Home Health Agencies (HHAs) are categorized as Low Population Density, High Utilization, or All Other. Low Population Density are those HHAs serving a geographic area with a population of 6 or fewer persons per square mile. High Utilization areas are those counties in the highest quartile of all counties based on the number of Medicare home health episodes furnished per 100 Medicare enrollees. The rural add-on will phase out in 2022 as follows:

| Category | CY2020 | CY2021 | CY2022 |
|---|---|---|---|
| High Utilization | 0.5% | NONE | NONE |
| Low Population | 3.0% | 2.0% | 1.0% |
| All Other | 2.0% | 1.0% | NONE |

The theory behind the variable add-on is that it is needed more in sparsely populated areas and less in areas that show a higher than average usage of home health services. If a rural county is both a low population density area and a high utilization area, the lower add-on and early phase-out applies. For a more detailed explanation, see https://www.govinfo.gov/content/pkg/FR-2019-11-08/pdf/2019-24026.pdf. Page 60541. The ultimate elimination of the add-on appears to be based on a view that it is eventually not needed. None of these assumption is well founded.

The three percent payment modifier to reimbursements for services provided in rural areas has been crucial to maintaining access to care. Rural agencies face higher overhead expenses due to increased travel time between patient visits, demands for extra staff, and the need to support the mandated infrastructure of a home health agency in low patient volume locales. This payment modifier is imperative so that rural agencies will be able to keep their doors open and provide necessary care to homebound patients.

**The latest data available (Cost Report Years ending in 2018) shows that the average financial margin for HHAs located in rural areas is negative 6.2%. In other words, the rural-based HHAs receive on average 6.2% less than the cost of care during a time with the add-on in effect at 3%. That average represents a wide range in margins. However, most notable is that 39.9% of such HHAs have Medicare margins below zero. This is in stark contrast to non-rural HHAs where less than 20% have negative Medicare margins in 2018.**

**The targeting theory set out in BBA 2018 and the CMS rulemaking does little if anything to provide the supports needed to make rural home health services viable. In an analysis done using 1387 cost report from rural-based HHAs (all of those available), an estimated 37.8% of HHAs (517) in the High Utilization category would experience margins below zero upon the elimination of the add-on. In Low Population Density areas, 68.9% of HHAs (74) would have negative margins. The remainder would have 57.3% of HHAs (802) paid less than the cost of care.**

NAHC takes issue with any MedPAC analysis of rural HHA Medicare margins in that the MedPAC analysis relies on a "weighted average" where the calculation lumps all HHAs together giving higher weight to those HHAs of larger size. Rural areas do not provide the population density for all HHAs to be of large size. A better measure is the one used here that evaluates based on each individual HHAs Medicare margin. A second and equally significant flaw in the MedPAC methodology is the exclusion of HHAs that are integrated into a health care system. In some rural areas, these are the only HHAs available. To exclude them from any calculation related to the need for the add-on is to ignore their role in essential access to care.

Congress has repeatedly determined, with bipartisan support, that the home health rural add-on is needed to maintain care access and quality in rural areas. Dating back to 2000, the Congress has continually extended the rural add-on with only minimal gaps. As initially applied to the Medicare Home Health Prospective Payment System, the add-on was set at 10%, and then decreased to 5%, followed by 3%. As referenced, the Bipartisan Budget Act of 2018 extended the add-on, but called for phasing it out, leaving many providers questioning how they will be able to stay in business.

With the increasing closure of rural hospitals and the continuing medically underserved populations in rural areas resulting from physician shortages, home health agencies have become a primary care lifeline for many patients. That is just one of the explanations available for the "high utilization" result as home health has become the only service available. It is also difficult to consider the categorizations as reasonable targeting when an area can be both high utilization and low population density.

There are higher costs for home care in rural areas primarily due to travel time and the cost of meeting Medicare standards for operation that disadvantage small, rural providers. Further, home health care is often the substitute for primary care in rural areas with the shortage of physicians. That translates to longer patient visits and lower staff productivity than possible in a short travel time non-rural location. A loss of access to care in rural areas negatively impacts patients and Medicare as care and its costs shift to institutional care. Finally, Congress has repeatedly supported, on a bicameral, bipartisan basis, a rural differential or rate add-on since the 1990s.

**What Congress Can Do**

Reinstate the 3% rural add-on for three years and require an expanded study on its application and any needed reforms to ensure its ongoing success. While targeting may be an option to consider, the current targeting approach is not reliable.

**New Medicare Home Health Payment Model: It Must Be Closely Monitored and Increased Transparency in Rate Setting Is Essential**

On October 31, 2019, the Centers for Medicare and Medicaid Services (CMS) finalized "CY 2020 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; Home Health Quality Reporting Requirements; and Home Infusion Therapy Requirements", its annual payment system update for the Medicare Home Health benefit. This rule finalized the Patient-Driven Groupings Model (PDGM) that took effect January 1, 2020. Included within the PDGM model is a preemptive reduction to the base payment rate of 4.36% derived solely from assumptions as to how home health providers might behave in their provision of care and documentation practices under the PDGM model. It is notable that this reduction, as included in CMS's proposed rule, was originally projected as 8.01% in what would have been the largest single year cut to payments since the inception of the home health prospective payment system nearly 20 years ago. The rate reduction is the equivalent of a one year cut of nearly $750 million in a Medicare benefit that totals $18 billion annually.

Under current law, CMS is authorized to make assumptions about prospective provider behavior in rate setting. The behavior change assumptions and the assumed level of impact can be modified annually, with a resultant impact on payment rates. The National Association for Home Care and Hospice (NAHC) greatly appreciates CMS's openness in reconsidering its proposed assumptions leading to a reduction in the rate cut. This was a solid step towards a more equitable payment model. However, the application of behavioral assumptions in prospective annual payment rate setting still greatly concerns NAHC, as does the limited information disclosed regarding the assumption-based calculations. Notably, the risk of relying on assumptions is highlighted by the significant change between the proposed and final assumptions. NAHC is also concerned that assumption-based rate setting actually will trigger provider behavior changes simply to sustain revenue neutrality. In this sense, behavior changes that might not otherwise occur become inevitable.

A payment model where new assumptions and corresponding rate adjustments can be made annually creates an unstable financial environment for providers, thereby posing an ongoing threat to continued operations and access to care for vulnerable Medicare beneficiaries.

NAHC strongly supports the Home Health Payment Innovation Act (S. 433 & H.R. 2573), which was introduced with bipartisan support in both the House and Senate. This important legislation would require rate adjustments based only on real, actual changes in provider behavior in response to the new payment model. With the finalization of the CY 2020 payment rule, it may be necessary to modify the legislation to focus on future years to improve the transparency of any additional behavior adjustments to payment rates and to restrict the use of bald assumptions as the sole or primary basis for such adjustments. These core reforms in the Home Health

Payment Innovation Act remain needed to ensure stability in the home health benefit and preserve access to care for the 3.5 million users of home health services.

NAHC greatly appreciates the actions to date and the ongoing bipartisan and bicameral support of the Congress on this issue as well as CMS for its reevaluation of their projected behavioral assumptions in issuing the final rule. Still, the reform recommended here is essential. As a starting point, it would be very helpful if Congress committed to closely monitoring access to care and changes in service utilization that may be driven by weaknesses in the payment model. There are early, anecdotal reports of access problems for patients in categories with reduced reimbursement levels to the HHAs.

In addition, Congress should call on CMS to provide full transparency on its data and any of its reasoning in future calculations of rate levels and rate adjustments. The CY2021 proposed rule is expected mid- year and CMS is currently working on its draft of that rule. Fair rulemaking and Medicare rate setting requires that CMS provide full disclosure so that affected parties can properly participate in the public rulemaking process.

**Innovative Use of Telehealth/Telehomecare Telehomecare is the use of technologies with the goals of:**

- Early detection and intervention of a potential health crisis.
- Empowerment of the patient for self-management through the collection and exchange of clinical information from a home residence to a home health/hospice agency, a secure monitoring site, or another health care provider via electronic means.

The scope of telehomecare includes, but is not limited to, the remote electronic monitoring of a patient's health status and the capturing of clinical data using wireless technology and sensors to track and report the patient's daily routines and irregularities to a healthcare professional; electronic medication supervision that monitors compliance with medication therapy; and two-way interactive audio/video communications between the provider and patient allowing for face-to-face patient assessment and self-care education.

The VA has broadly deployed a range of remote patient monitoring (RPM) technologies and conducted various studies showing improved chronic disease management, cost savings and reduced hospital admissions and emergency department (ED) visits as the result. In 2012, the VA also eliminated copayments for veterans receiving in-home care via telehealth technology.

Unfortunately, the Centers for Medicare & Medicaid Services (CMS) does not recognize telehomecare as a distinctly covered benefit under Medicaid, nor does it allow HHAs to be reimbursed for telehomecare technology costs by Medicare. The absence of payment for non-physician telehealth interactions and restrictive federal Medicaid and Medicare telehomecare guidelines are barriers to more widespread adoption of telehealth.

Most recently, the Bipartisan Budget Act of 2018 included provisions that expand the ability of MA plans and Accountable Care Organizations (ACOs) to offer telehealth services. However, Medicare beneficiaries generally still not have access to telehomecare.

Beyond Medicare benefit limitations, many rural areas across the United States – the very areas that could most benefit from use of telehomecare technologies -- do not have Internet access sufficient to enable its use. The Administration, Congress, states, and carriers must take action to address this serious deficiency.

At the same time, the technology sector is rapidly developing other valuable new technologies, many of which will help to promote aging in place, while others may provide sufficient advance warning of potential changes in health status that they could reduce acute exacerbations of serious health conditions. These hold great promise for more effectively addressing health care needs of community-based senior citizens. Technologies for use in the delivery of home health and hospice care are increasingly being recognized as essential tools for an industry challenged by an exponential growth in the number of patients over 65 with chronic disease, a shortage of skilled professionals to handle the increased senior population and by diminished reimbursement formulas. Through the effective use of such technologies, the overarching goals of keeping patients safely at home and reducing emergent and acute care spending can be realized.

Congress should:

1.) Establish telehomecare services as distinct benefits within the scope of federal Medicare and Medicaid coverage to include all present forms of telehealth services. As part of these benefits, Congress should allow sufficient flexibility to adopt coverage of emerging technologies, and to allow costs associated with them for cost reporting purposes;

2.) Clarify that telehomecare qualifies as a covered service and permit visit equivalency under the Medicare home health and hospice benefits (including under MA);

3.) Authorize the home as an originating site for telehealth services by physicians under section §1834(m) (3) (C) and provide greater flexibility for the use of remote patient monitoring services;

4.) ensure that all health care providers, including HHAs and hospices (especially those in rural areas with limited availability of health care/clinical providers), have access to appropriate bandwidth so that they may take full advantage of technology appropriate for the care of homebound patients;

5.) Hold cellular carriers accountable to incentives provided by states to expand broadband to rural regions; and

6.) Direct CMS' Centers for Medicare & Medicaid Innovation (CMMI) to study the impact that early adoption of technology has had on access to care and reductions in overall health care costs, as well as to develop demonstration projects that identify the impact that coverage of various technologies can have on care utilization by patients who would otherwise be high utilizers of care.

Telehomecare is a proven and important component of health care today and vital to reducing acute care episodes and the need for hospitalizations for a growing chronic care population. Establishing a basic federal structure for Medicare and Medicaid reimbursement and coverage of telehomecare services will permit states to more easily add this important service to the scope of Medicaid coverage and benefit the entire Medicare program. Studies indicate that over half of all activities performed by a home health nurse could be done remotely through telehomecare.

Evidence from these studies has shown that the total cost of providing service electronically is less than half the cost of on-site nursing visits. More specifically, the use of telehealth technologies in both urban and rural areas would help defray additional transportation cost and travel time and also improve the utilization of scarce nurses and therapists. With telehomecare a single clinician is able to care/case manage a larger number of patients than under the traditional in-person visit model. Given the growing financial constraints on agencies -- especially in rural settings -- providers of care should be granted maximum flexibility to utilize cost-effective means for providing care, including nontraditional services such as telehomecare that have been proven to result in high-quality outcomes and patient satisfaction, and emerging technologies.

**Workforce Shortages in Home Care Need to be Addressed**

Evidence is mounting that the workforce available to provide care in the homes is insufficient to meet the current needs of the nation's elderly and persons with disabilities. The shortages involve all disciplines of caregivers, but it is particularly acute with nurses, home health aides and personal care attendants. With the aging of America, the shortages will only grow and grow exponentially unless a national home care workforce strategic plan is developed and implemented.

The shortages are likely due to a myriad of reasons including the disproportionate population level of elderly, limitations on health care educational resources, the difficulties of the work itself, compensation, career opportunities, and the inadequate respect for caregivers, to name a few of the possible explanations.

Remedial actions have been ongoing for many years, but they have made only a small dent in addressing the needs. Given that the causes of worker shortages are multi-dimensional, it is apparent that multi-dimensional solutions must be explored.

NAHC is ready and willing to participate as one of the voices needed to evaluate and craft viable solutions. We do not hold any claim to knowing what all the solutions may be. However, we sincerely believe that solutions can be found through a broad partnership of stakeholders, including Congress, committed to the effort.

**Conclusion**

The National Association for Home Care & Hospice extends its sincere thanks to the Special Committee on Aging for its attention to the important area of home health care in rural America. We also thank the Committee for the opportunity to submit this testimony and we look forward to working with the Committee on its efforts to ensure access to high quality of care at home.

**Rural Home Health, Homecare, and Family Caregiving**

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**Rural Home Health, Homecare, and Family Caregiving**

"My histories and physicals are incomplete until I have had a meal with the patient and their family in their home." Made famous in part by Robin Williams' semibiographical portrayal of the West Virginia physician, Dr. Patch Adams understands rural home care. I made my first home health nursing visit in 1985. There is peace in the view of the countryside, the swamps and marshes of south Louisiana, and the Cajun prairies. A trained eye also notes the unique public health issues in rural areas. Pulling into a driveway a health professional notes the socioeconomic status of the family. A knock on the door and stepping across the sacred threshold of the patient's home offers an opportunity to evaluate the nature of the patient environment and the engagement of significant others. The home visit adds critical information to the patient assessment.

Madame Chair, Ranking Member Casey, U.S. Senate Committee Members, staff, and guests, home health, non-medical home care, and family caregiving are happening across the country as we gather here for this vital hearing. Depending on the resource one cites, as many as 45 million family caregivers assist loved ones each year. AARP reports that daily, between seven and eight million family members, provide care to a person in need. Informal, unpaid, family caregivers provide between 80% – 90% of all long-term care for the elderly and those with functional and cognitive exceptionalities. My wife and I are family caregivers of a 29-year-old daughter with Down Syndrome. My mother, my nine siblings and I provided care for my father who had dementia. Over his seven-year journey, with the help of family, hospice, and home health, Dad did not spend one night away from home.

Families like ours are supported by my colleagues, skilled home health nurses, aides, therapists, social workers, and other professionals. The non-medical homecare profession is one of the fastest growing job categories in the United States. Providing meals, personal hygiene, and custodial support, the Home Care Association of America reports these workers will account for 2.3 million jobs by 2024. Rural conditions make finding workers and family caregivers significantly more challenging.

Across the nation, fewer rural beneficiaries receive home health, 5.5%, than those in urban counties, 8.8%. The average number of care episodes is also lower for patients in rural areas. These figures are in spite of rural communities' higher rates of chronic illness and disabilities. Home health patients are also more likely to live at or below the Federal Poverty Line than those in urban areas. Other aspects of social determinants of health also favor urban home health clients, over those who reside in rural communities.

**Existing Successes and Promising Projects**

Value-based care has led us away from a sick-care, acute care-centric model, to a more proactive, prevention and wellness focused approach to *health focused care,* better aligning incentives to proactive care and services at home. Innovative care at home programs may show promise when applied in rural areas.

- The Veteran's Administration's Home-Based Primary Care program's physician and nurse practitioner led, multidisciplinary teams have gone into homes for almost 20 years. The VA program's success led to the Independence at Home (IAH) Demonstration for chronically ill patients, which began in 2012 and has been extended to December 2020. The Centers for Medicare and Medicaid Services calculated the IAH model saved $1, 431 per overall Medicare beneficiary expenditures, a 4.7% savings over patients with similar care needs.
- Dr. Sarah Szanton's *Community Aging in Place- Advancing Better Care for Elders* (CAPABLE) model, involves a nurse, occupational therapist, and a home repair person/handyman, adapting home settings for seniors. Roughly $3,000 in CAPABLE program investment results in more than $20,000 in savings in medical costs from inpatient and outpatient services.
- Dr. Bruce Leff's initiative, the *Hospital at Home,* has resulted in fewer complications and lower costs.

Sutter Health's Advanced Illness Management (AIM) program again included inter-professional groups of physicians, home health nurses, hospice professionals and data analysts. Patients with a 90-day engagement in Sutter's AIM program had a 59% reduction in hospitalizations, a 19% reduction in emergency room visits, and 67% fewer days in costly intensive care units.

**Potential Solutions for Rural Providers**

- Address homebound definition, and medical necessity criteria to expand eligibility for rural patients to receive care to observe and monitor chronic illness
- Support technology infrastructure to address connectivity and bandwidth issues, reducing the number of *dead-zones* for telehealth, telemedicine, and even just cellular coverage in rural areas
- Explore rural solutions to more burdensome face to face requirements
- Engage in solutions for both patient medical transportation problems in rural areas
- Recognize and reimburse fairly for the high cost of traveling to make home health visits, sometimes as much as two hours away from staff members' homes
- Recognize and compensate fairly to account for workforce challenges in rural areas
- Establish partnerships to address both skilled and non-medical rural workforce development
- Allow nurse practitioners and physician assistants to sign home health orders, as rural providers are often NPs and PAs, sometimes more than an hour away from a physician collaborator (Thank you Madame Chair for your longtime commitment to this issue)

Madame Chair, Ranking Member Casey, and committee members, it is well documented that our rural communities are dying across America. Small farmers are selling to large conglomerates. The businesses once supported by farmers, and the employees of rural plants and manufacturers, are closing as our population continues to move into urban and suburban areas. Infrastructure

issues abound, schools are closing, and the tax-base is disappearing. As rural hospitals continue to close, pharmacies, physician practices, and home health providers also close or relocate.

Head of MIT's Age Lab, Dr. Joseph Coughlin, Tweeted last year, "Independence is overrated. It is interdependence we should be seeking." I hope that this hearing is a catalyst for a more vibrant, lively conversation about *interdependence*, as we work to more effectively engage and support those that depend on home health across rural America. Thank you.

**Testimony to the Senate Special Committee on Aging Hearing**
**"There's No Place Like Home: Home healthcare in Rural America"**
**February 12, 2020**

**Francis Adams, Home Care Worker**

Good morning Chairman Collins, Ranking Member Casey, and Senators. My name is Francis Adams, I'm 70 years old and I am a home care worker from Washington, Pennsylvania. I'm also a very proud member of the United Home Care Workers of Pennsylvania, a joint program of SEIU Healthcare PA and AFSCME. I've been a home care worker for more than 20 years, helping seniors and people with disabilities who need support to remain at home instead of being placed in a facility. From my first-hand experience, I can see our current long-term care system does not support home care workers or the clients who need our services.

The thing about home care is that there's always work. Every day, more than 10,000 people turn 65 in America.[1] In Pennsylvania alone, 70 percent of people turning 65 need some type of long-term care.[2] But, in my state, there is only one home care worker for every eight people in need of services.[3] As a whole, our country needs to attract one million more workers to the home care industry by 2028 to meet the skyrocketing demand.[4] However, for a job that's in such high demand, home care is one of the lowest-paid and most under-supported workforces in the country.

When I was younger, you could quit your job at the steel mill, walk across the street to another mill and get another job in ten minutes. Today, that's home care. There are so many open jobs, but it's hard work and people aren't going to fill open positions if they can get paid more at a CVS. Home care work was a lifeline for me after the mills I worked at went under. By the time my pension kicked in, it was only a small fraction of what had been promised, so being able to do home care kept me afloat. However, despite the importance of this work, it does not pay as well, which continues to be a problem.

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[1] Heimlich, R. (2010, December 29). Baby Boomers Retire. Retrieved from https://www.pewresearch.org/fact-tank/2010/12/29/baby-boomers-retire/
[2] Pennsylvania Health Care Association. Long-Term Care Trends and Statistics, The Need for Long-Term Care Continues to Grow. Retrieved from https://www.phca.org/for-consumers/research-data/long-term-and-post-acute-care-trends-and-statistics
[3] Home Care Fight for $15. Care Gap Report. Retrieved at https://fightfor15homecare.org/care-gap-report/
[4] Scales, K. (2019). *Envisioning the Future of Home Care.* Retrieved from https://phinational.org/wp-content/uploads/2019/10/The-Future-of-Home-Care-2019-PHI.pdf

With our current system, low wages (a median wage of $11.57 per hour[5]), lack of benefits and basic protections, and isolation contribute to a critical shortage[6] of home care workers. National workforce turnover rates were as high as 60 percent in 2014.[7] Many home care workers don't have affordable healthcare, and go years without seeing a doctor. More than half of all home care workers rely on public assistance. We're unable to meet our basic needs.

I started my career in home care when my grandfather fell ill from black lung. I left my job as a steelworker to return to my family. I wasn't paid for the work, but it didn't matter to me — I wanted to be there for my family. I later started taking care of my aunt, and that's when someone told me that home care can be a profession. I really like the work, and I know how much people need it, so I started taking on other clients.

In addition to acting as a family caregiver to my brother who is blind from diabetes, I serve my community as an on-call home care worker, meaning I step in when a client's regular caregiver is unavailable. I never know what time of day the call will come, but when it does, I answer. If I don't, who will? They don't have anyone else and need someone to be there for them. As long as I'm physically able to do so, I promise to be that person.

A lot of the tasks I do in home care are physical — bathing, cooking meals, cleaning, helping clients go to the bathroom, driving them to and from appointments, helping them get in and out of bed — but it's the emotional connection that really makes an impact. You might be the only person they talk to all day, or maybe even all week. I never want to leave a client alone — depression and mental illness can kill you just as fast as lung cancer. And because I work as an on-call home care worker, often times I don't know what equipment someone has in their home. It is why training is so important — if I don't know how to properly use equipment, then I can hurt myself or my client.

Western Pennsylvania isn't like Washington, D.C. As a rural area, we can't walk across the street to the grocery store or hop on a subway to get across town. Isolation and distance are huge issues for people in communities like mine. Neighbors are separated by several miles. I don't own a car, so to get to my clients, I sometimes have to borrow my stepchildren's or friends' cars. When I don't have a car to use, I take the bus. But the buses only run at certain times, so if I miss it, I walk.

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[5] U.S. Department of Labor, Bureau of Labor Statistics. (2019, September 4). *Occupational outlook handbook.* Retrieved at https://www.bls.gov/ooh/healthcare/home-health-aides-and-personal-care-aides.htm
[6] Farrell, Chris. (2018, April 18). The Shortage Of Home Care Workers: Worse Than You Think. Retrieved at https://www.forbes.com/sites/nextavenue/2018/04/18/the-shortage-of-home-care-workers-worse-than-you-think/#34f2fc093ddd; Institute of Medicine. (2008) *Retooling for an Aging America*. The National Academies Press: Washington DC.
[7] Ozga, M. (2015, April 28). SURVEY: Home Care Worker Turnover Topped 60 Percent in 2014. Retrieved from https://phinational.org/survey-home-care-worker-turnover-topped-60-percent-in-2014/

For those in need, it takes much longer for emergency services like fire trucks and ambulances to arrive at the scene. Because my clients can't get to the store, whether it's because of distance or mobility issues, sometimes they run out of vital supplies like dish soap, paper towels, toilet paper, or over the counter medications. I am the one who makes sure that my clients have the basics. For these reasons, home care workers are all the more important for those who live in rural areas — we are truly their lifeline.

Many of my clients are living in deep poverty themselves. I remember one client shut all his lights off at 7 p.m. because he couldn't afford electricity. So here's this guy, sitting in the dark all night long. It's really disheartening to see people sitting there like that — they can't watch TV, listen to the radio or read a book. Even if they can afford cable, lines might not run out to rural areas. So you can see in these cases, having a caregiver there to care for and talk with them is especially important.

And because there is not enough funding for home care and our clients are struggling themselves, home care workers like me may have to pay out of our own pockets for things like transportation or supplies. I have had to do that, and it only adds to the financial burden of the job. I make $10.70 an hour, and I work anywhere from 10–40 hours any given week, depending on how many calls I get. I do my best and work hard to support myself and my brother with what we have. In addition to working as a home care worker, I have to work a second job in retail to make ends meet. But if home care was a better paying job, I wouldn't have to take on other work.

We can't truly improve the long-term care that seniors and people with disabilities rely on unless we tackle the major obstacles that are holding working people back, including low wages, lack of benefits and basic worker protections, and inadequate training. It isn't that we don't have enough people to do this work that creates a workforce shortage, it is that our country, as a whole, undervalues this work and so nobody wants to fill the positions. We have to fix this. We have to invest in long-term care for all and we have to finally respect the work home care workers do.

That is why I am joining Pennsylvania home care workers and workers across the country to raise wages to at least $15 per hour. To win a living wage, home care workers like me are uniting in unions to improve the lives of themselves and their clients.

Through my union, my fellow home care workers and I have the strength in numbers to negotiate for higher wages, basic benefits and for training programs. My union gives me opportunities I never thought possible. We have worked together to get the Pennsylvania government to strengthen the commonwealth's Medicaid program. My union provides me with critical training I might not otherwise get. And importantly, my

union has given me a sense of community. I even found out that there are three other home care workers that live in my building.

The union is everything to me. My grandfather was a miner and a union member, my father was a steel worker and a union member, and my mother was a teacher and a union member. I saw what the unions did to improve life for our family, and I see now what our union is doing for home care workers like me.

I have advocated for racial and social justice my entire life. As a child, I saw first-hand how the shameful legacy of Jim Crow held hardworking people in my community back. I joined my parents as we marched arm and arm with Dr. King and I held that power and passion in my heart as I grew older. Coming of age in the late 1960s and early 1970s, I upheld my commitment to justice, standing with my sisters and brothers of all backgrounds as we protested the Vietnam War and fought against oppression during the Stonewall uprisings. Our strength then paved the way for justice today, but we know there is more work to do. Even now, in 2020, prejudice and hatred permeate our society, with those in economic power shamelessly and willingly enacting sexist, racist policies that revive the demons of our past. Home care, a job that has historically (and falsely) been labelled "unskilled" and "women's work," is a clear example of this. This cannot stand. The things we were advocating for in the 60s are now mainstream parts of our culture, and, similarly, I hope what we're calling for today will make home care mainstream, top-notch and dignified work, so that in 20 years, supporting our elderly at home isn't even a debated question.

At 70 years old, I'll soon need someone to care for me like I do for my clients and my brother. I want to make sure that the future of home care is made up of good, qualified, compassionate workers who are able to do the job to the best of their ability. As a consumer, I want to make sure that I'm not left in the dark because my caregiver can't get to me or that they're too sick to work.

The aunt I cared for once told me, "If I'm gonna die, I'm gonna die in my own bed." People want to live in their homes — I've never once heard someone say they wanted to go to a nursing facility. Home is where they're the most comfortable. It's where their family is. It's what they spent their whole live building. It's what they know. I want that for myself, too.

It is why I ask that Senators do everything they can to make it easier for people to receive care in their homes. We have starved our long-term care system, and all the Medicaid cuts proposed by the President will only make it worse. I want to thank Senator Casey for introducing the Home and Community-Based Services (HCBS) Infrastructure Improvement Act. This bill will give more money to states to make sure that as many people as possible have access to care in their community. It will help

states support things like transportation and encourage states to increase wages and provide training for home care workers. The funding Pennsylvania could receive if this legislation passed would mean I could have real hope for a raise. And that is true for home care workers across the country if their states pursued workforce improvements under the bill.

Home care work is this country's future. It's never going away, and funding for home care must increase if we're going to make sure every person in this country — home care workers and those who need the services — has hope for a good life.

Thank you.

## Questions for the Record

U.S. Senate Special Committee on Aging
**"There's No Place Like Home: Home Health Care in Rural America"**
February 12, 2020
Questions for the Record
**Mr. Francis Adams**

**Senator Richard Blumenthal**

**Question:**

Home care workers are paid far too little and receive little to no benefits. Thankfully, unions have been able to helping to organize home care workers, as you mentioned in your testimony, push for fair wages, benefits, and working conditions. As a result of unionization, Connecticut home care workers received a raise to $15 an hour in 2018 and gained access to the state's worker compensation system.

In July of 2018, CMS issued a Notice of Proposed Rulemaking that would prohibit home care workers under Medicaid from making deductions from their pay for benefits including paid time off, training, and voluntary union membership. The proposal is representative the Administration's policy of undermining union members, workers' rights, and home care workers specifically. At the time, I sent a letter to CMS with the rest of the Connecticut delegation criticizing the agency's attack on workers' rights.

1. ***Can you speak to what your union means to you and other home care workers?***

2. ***What would it mean to you if the Administration prevented you from contributing your paycheck to union dues and other needed, and deserved, benefits?***

**Senator Doug Jones**

**Question:**

I agree that professional development is so important for turning these jobs into fulfilling sustainable careers. What types of trainings would be helpful in achieving this and in improving both workers' and clients' safety and contentment?

**At this time, responses are not available for printing. Please contact the U.S. Special Committee on Aging for further updates and to perhaps obtain a hard copy, if available.**

U.S. Senate Special Committee on Aging
**"There's No Place Like Home: Home Health Care in Rural America"**
February 12, 2020
Questions for the Record
**Mr. William A. Dombi**

**Senator Richard Blumenthal**

**Question:**

In a statement in response to the President's budget request last year, which proposed cuts to Medicaid and block granting Medicaid, you expressed the need for increased investment, rather than disinvestment in Medicaid. The Fiscal Year 2021 proposed budget that was released on Monday includes $1 trillion in cuts to the program over the next 10 years.

With home care providers already suffering from financial pressure and low reimbursements, it is likely that Medicaid cuts could devastate the industry. In Connecticut specifically, successful programs like Connecticut Community First Choice (CFC), which helps connect residents with home care, could be impacted.

1. ***Do you share the same feeling now in regards to Medicaid funding-- in response to the President's Fiscal Year 2021 budget request?***

2. ***Can you share how exactly cuts of this magnitude could impact the home care industry—as well as patients?***

**At this time, responses are not available for printing. Please contact the U.S. Special Committee on Aging for further updates and to perhaps obtain a hard copy, if available.**

U.S. Senate Special Committee on Aging
**"There's No Place Like Home: Home Health Care in Rural America"**
February 12, 2020
Questions for the Record
**Ms. Leigh Ann Howard**

**Senator Doug Jones**

**Question:**

Though telehealth is not a substitute for all home care, it can certainly help to fill critical gaps for rural patients. The telemonitoring program that you oversee has had a tremendous impact on the more than 300 patients under your care. Unfortunately, poor broadband access is also an issue in Alabama and has limited such services' reach in my state as well. How would improving rural broadband services benefit your work and would could this mean for your patients?

**Response:**

Thank you for the question. Improved access to broadband in those areas without cell connectivity would allow an opportunity for more rural patients to participate in the telemonitoring program. Better connectivity would also allow us to use video conferencing. Video conferencing adds a human connection for many seniors who may feel isolated from affects of their chronic illness and rurality. Many times, the seniors build relationships with the home telemonitoring staff. They look forward to the phone calls and find comfort in having the human connection even if just for a few minutes. Opportunities for group video conferencing can help bridge the gap between the patient, family members, home health staff, and physicians. The ability to utilize video would also help expand telehealth visits to provide tele-wound care, tele-speech, and telep-physical therapy services as well.

Unfortunately, some of the most vulnerable patients may also face a cost barrier to access broadband. Any federal assistance in expanding broadband should be tied to low cost options for seniors with demonstrated economic need.

In areas where we do not have access to cell signal or broadband, we complete daily phone calls to gather the patient's information. It is then recorded in their chart. In a time of workforce shortage this adds to an already significant work load. Improved broadband and improved cell connection would assist in the fluidity of information and potential to bring remote video service into the patient homes.

## Additional Statements for the Record

U.S. Senate Special Committee on Aging
**"There's No Place Like Home: Home Health Care in Rural America"**
February 12, 2020
Statement for the Record

**Senator Tim Scott**

For more than 40 years, home infusion providers have been safely and effectively coordinating and delivering intravenous and subcutaneous infused medications in patients' homes. Home infusion therapy empowers patients with serious infections, heart failure, immune diseases, cancer and other conditions to remain at home, where they can generally maintain their personal and professional activities. For rural patients unable to easily access traditional health care centers, access to home infusion services enhances quality of life and improves treatment adherence.

With all of this in mind, it comes as no surprise that patients overwhelmingly prefer to receive their treatments at home, when possible. In fact, research shows that up to 95 percent of patients prefer receiving their infusions at home, and 98 percent of patients surveyed last year indicated they are highly satisfied with their home infusion services. Additionally, as the commercial market has long recognized, home infusion is incredibly cost-effective. Commercial insurers have increasingly embraced home infusion as a high-quality, economical benefit, with savings passed on to the patient in the form of reduced out-of-pocket costs.

Unfortunately, CMS' current reimbursement policy has created significant barriers to access, imperiling the viability of Medicare's home infusion benefit. Without robust access to home infusion, patients are often forced to remain in a facility overnight or travel to a separate location to receive their infusion treatment, sometimes multiple times a day. This problem is all the more pressing in rural areas, where patients may require treatment on a daily basis and live an hour or more away from the closest infusion center. We also see substantial challenges for products used to treat rare diseases. Medicare will not cover permanent administration of home-infused therapies listed on a self-administered drug list beginning in 2021 (such drugs are presently covered), and Medicare rejects coverage of novel home-infused therapies approved by the FDA, such as subcutaneous immune globulin, in treating the rare disease of Chronic Inflammatory Demyelinating Polyneuropathy.

For South Carolina, addressing home infusion access barriers has become a major need. As of 2018, more than 1.05 million South Carolinians were enrolled in Medicare, representing roughly 21% of the state's population. We also have a sizable rural population; more than 744,000 Palmetto State residents live in rural areas, comprising around 15% of the total SC population. Fortunately, our state is host to some of the nation's most effective home infusion therapy providers. This could change, however, if payment policy challenges remain unresolved.

I urge the Committee for their support in efforts to remedy Medicare's home infusion benefit, so that we can ensure seniors receive care in the setting that works best for them.

**United States Senate Special Committee on Aging**

**"There's No Place Like Home: Home Health Care in Rural America"**

**Statement for the Record**

**National Community Pharmacists Association (NCPA)**

**February 12, 2020**

Chairman Collins, Ranking Member Casey, and Members of the Committee:

Thank you for conducting this hearing that aims to address stakeholder viewpoints on current actions and future solutions to enhance home health care in rural America. The National Community Pharmacists Association (NCPA) appreciates the opportunity to provide a statement for the record to the Senate Special Committee on Aging. NCPA represents America's community pharmacists, including 21,000 independent community pharmacies. Almost half of all community pharmacies provide long-term care services and play a critical role in ensuring patients have immediate access to medications in both community and long-term care (LTC) settings.[1] Together, our members represent a $76 billion healthcare marketplace, employ approximately 250,000 individuals, and provide an expanding set of healthcare services to millions of patients every day. Our members are small business owners who are among America's most accessible healthcare providers, typically located in underserved rural areas where patients do not have access to multiple pharmacy locations. NCPA submits this statement on behalf of both community and LTC independent pharmacies. NCPA is committed to working

[1] *NCPA 2018 Digest* (2018).



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collaboratively with Members of Congress, the Administration, and other stakeholders in furthering viable solutions to increase access to home health care in rural areas.

As the Committee is aware, almost 2 million people over the age of 65 (excluding LTC facility residents) rarely or never leave their homes.[2] Homebound patients are sicker than most, many with progressing dementia and depression, struggling to complete activities of daily living and manage complexities of their medications.[3] However, the number of skilled nursing facility beds/nursing homes is expected to remain stagnant.[4]

NCPA writes to bring attention to the value of LTC independent pharmacists in providing skilled service to their patients in a home setting, also known as "medical at home" pharmacy services, especially in underserved areas. To meaningfully address the increasing aging population who require assistance with activities of daily living, we urge the Committee to work with the Centers for Medicare and Medicaid Services (CMS) to recognize medical at home pharmacy services and issue guidance formally recognizing these services **at the same level** as other LTC services. [5] Independent LTC pharmacies are best situated to provide medical at home pharmacy services to an indigent population as well as patients in the Medicaid and Medicare programs. Many pharmacies offering LTC services

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[2] Ornstein KA et. al, *Epidemiology of the Homebound Population in the United States*, JAMA Intern Med. 175(7): 1180-1186 (2015).
[3] *Id*.
[4] Mark Mather, *Fact Sheet: Aging in the United States*, PRB (July 15, 2019), *available at* https://www.prb.org/aging-unitedstates-fact-sheet/; Paula Span, *At Home, Many Seniors are Imprisoned by Their Independence*, NY Times (June 19, 2015), *available at* https://www.nytimes.com/2015/06/23/health/at-home-many-seniors-are-imprisoned-by-their-independence.html?ref=health&_r=2.
[5] *See,* "Overview of Medical at Home Pharmacy Services" NCPA (June 2019), *available at* http://www.ncpa.co/pdf/medical-at-home-services.pdf.

provide specialized care to patients in their homes who might otherwise be in a nursing home due to their need for extra clinical services. LTC pharmacies routinely offer emergency support and services to the homebound, such as specialized packaging with home delivery, regular communications with prescribers, medication adherence programs, and value-based comprehensive medication management (CMM), working with the homebound patients' core interdisciplinary team.[6] These medical at home services, among others, can decrease errors and increase patient compliance.

Currently, CMS does not recognize or utilize medical at home services even though the National Council for Prescription Drug Programs (NCPDP), in November 2015, approved one new level of service referencing medical at home services with special pharmacy services identical to those provided to LTC nursing facility beneficiaries (not including emergency kits). [7] In order for LTC pharmacists to submit these services to their contracted payers/pharmacy benefit managers (PBMs) and be compensated accordingly, we need CMS to issue guidance formally recognizing the medical at home NCPDP level of service. Specifically, we ask the Committee to work with CMS to recognize NCPDP patient residence code "1" (home) with level of service "7" (medical at home), along with pharmacy type of "5" for long term care, at the same level as patient residence code "3" (nursing facility) or "9" (intermediate care facility/mentally retarded) to indicate that medical at home services are comparable to covered LTC services under Medicare Part D.

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[6] Medicare Prescription Drug Benefit Manual – Chapter 5, CMS (Sept. 20, 2011), *available at* https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/MemoPDBManualChapter5_093011.pdf.

[7] NCPDP Data Element Request Form (DERF)/External Code List (ECL); DERF #: 001306 (July 13, 2015).

LTC pharmacists, working with homebound patients and their core interdisciplinary team, help limit hospital readmissions, contain health care costs, and respond to the shifting paradigm of value over volume services. However, as stated above, until CMS recognizes medical at home pharmacy services, PBMs will not change their payment structures for these services for Medicare Part D beneficiaries. **Therefore, we ask that the Committee collaborate with CMS to formally recognize and promote medical at home pharmacy services to help improve value-based patient care, increase savings to the health care system, and ensure pharmacy providers are fairly and properly reimbursed for their services.**

**Conclusion**

NCPA urges the Committee to consider expanding and utilizing medical at home pharmacy services when determining new policies to help expand home health care, especially in rural areas. NCPA is committed to continue assisting the Committee and other industry stakeholders in developing such viable solutions.

AANP | American Association of NURSE PRACTITIONERS™

*The Voice of the Nurse Practitioner®*

**Statement for the Record**
**American Association of Nurse Practitioners**
**For The**
**United States Senate**
**Special Committee on Aging Hearing:**
**"There's No Place Like Home: Home Health Care in Rural America"**
**February 12, 2020**

On behalf of the more than 100,000 individual members of the American Association of Nurse Practitioners (AANP), and the over 270,000 nurse practitioners (NPs) across the nation, we appreciate the opportunity to provide the following statement for the record to the United States Senate Special Committee on Aging (the Committee). We commend the Committee for holding this hearing on home health care in rural America and for highlighting the critical role of nurse practitioners in meeting the needs of patients receiving home health care, as well as the entire continuum of health care.

We applaud Chairwoman Collins and Senator Cardin for championing the *Home Health Planning Improvement Act of 2019*, (S. 296). This vital bipartisan legislation will create timely access to home health care for Medicare beneficiaries who receive their care from NPs. The *Home Health Care Planning Improvement Act of 2019* has been introduced with bipartisan support in several congresses and we appreciate that the Committee is highlighting it in today's hearing. In the 116th Congress, this bipartisan legislation currently has 43 cosponsors in the Senate and the companion legislation in the House of Representatives has 134 cosponsors. The time for swift passage of S. 296 is now and we applaud the Committee for their efforts here today.

As you are aware, nurse practitioners are advanced practice registered nurses who are prepared at the masters or doctoral level to provide primary, acute, chronic and specialty care to patients of all ages and walks of life. Daily practice includes, assessment; ordering, performing, supervising and interpreting diagnostic and laboratory tests; making diagnoses; initiating and managing treatment including prescribing medication and non-pharmacologic treatments; coordinating care; counseling; and educating patients and their families and communities. NPs hold prescriptive authority in all 50 states and the District of Columbia (D.C.) and perform more than one billion patient visits annually.

NPs practice in nearly every health care setting including home health, long-term care facilities, nursing homes, hospitals, Veterans Health Administration and Indian Health Services facilities, emergency departments (EDs), urgent care sites, private physician or NP practices (both managed and owned by NPs), schools, colleges, retail clinics, public health departments, nurse managed clinics, and homeless clinics. NPs deliver high-quality, cost-effective care to those in rural and underserved areas. Research shows that NPs are more likely to practice in rural areas and areas of lower socioeconomic and health status than physicians.[1,2,3]

Currently, twenty-two states and D.C. are considered full practice authority (FPA) because their licensure laws allow full and direct patient access to NPs.[4] No state has ever moved away from FPA once it has been enacted, including Maine which has had full practice authority for two decades. In FPA states, NPs are authorized to practice to the full extent of their education and clinical training without a regulated relationship with a physician or health care institution. In non-FPA states, NPs are authorized to perform these services, but are required to have a formal, regulated relationship with a physician as a precondition to providing patient care. However, in

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[1] Davis, M. A., Anthopolos, R., Tootoo, J., Titler, M., Bynum, J. P. W., & Shipman, S. A. (**2018**). Supply of Healthcare Providers in Relation to County Socioeconomic and Health Status. *Journal of General Internal Medicine*, 4–6. https://doi.org/10.1007/s11606-017-4287-4.

[2] Xue, Y., Smith, J. A., & Spetz, J. (2019). Primary Care Nurse Practitioners and Physicians in Low-Income and Rural Areas, 2010-2016. *Journal of the American Medical Association*, *321*(1), 102–105.

[3] Andrilla, C. H. A., Patterson, D. G., Moore, T. E., Coulthard, C., & Larson, E. H. (2018). Projected Contributions of Nurse Practitioners and Physicians Assistants to Buprenorphine Treatment Services for Opioid Use Disorder in Rural Areas. *Medical Care Research and Review*, *Epub ahead*. https://doi.org/10.1177/1077558718793070

[4] https://www.aanp.org/advocacy/state/state-practice-environment.

both FPA and non-FPA states, certain Medicare and Medicaid regulations are more stringent than state law for nurse practitioners, including federal regulations for home health care.

One of the primary issues impacting the Medicare and Medicaid programs is a clinician shortage, particularly in primary care, that is being exacerbated by an aging population.[5] As our nation seeks to find solutions to ensure an effective and efficient health care system, we need to look no further than the more than 270,000 NPs who are providing high-quality health care every day. Nurse practitioners are providing the high-quality,[6] cost-effective[7] health care that our communities require, and will continue to do so to meet the future needs of their communities.

As of 2017, there were more than 130,000 NPs billing for Medicare services, making NPs the largest and fastest growing Medicare designated provider specialty.[8] Based on Medicare's claims data, approximately one out of every three Medicare patients receives billable services from a nurse practitioner.[9] Over 82% of NPs are accepting new Medicare patients and 80.2% are accepting new Medicaid patients.[10] NPs have a particularly large impact on primary care, as approximately 73% of all NP graduates deliver primary care.[11] NPs comprise at least one-quarter of the primary care workforce, with that percentage growing annually,[12] and they comprise an even larger portion of our health care workforce in rural and underserved areas.[13] NPs are the second largest provider group in the National Health Services Corps[14] and the number of NPs practicing in community health centers has grown significantly over the past decade.[15]

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[5] Impact of State Scope of Practice Laws and Other Factors on the Practice and Supply of Primary Care Nurse Practitioners, Final Report, page 4. https://aspe.CMS.gov/system/files/pdf/167396/NP_SOP.pdf.
[6] https://www.aanp.org/images/documents/publications/qualityofpractice.pdf.
[7] https://www.aanp.org/images/documents/publications/costeffectiveness.pdf.
[8] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/2017/Downloads/PROVIDERS/2017_CPS_MDCR_PROVIDERS_6.PDF
[9] http://medpac.gov/docs/default-source/reports/jun19_ch5_medpac_reporttocongress_sec.pdf?sfvrsn=0.
[10] 2018 AANP National Nurse Practitioner Sample Survey.
[11] https://www.aanp.org/about/all-about-nps/np-fact-sheet.
[12] Barnes, H., Richards, M. R., McHugh, M. D., & Martsolf, G. (2018). Rural and nonrural primary care physician practices increasingly rely on nurse practitioners. *Health Affairs*, *37*(6), 908–914. https://doi.org/10.1377/hlthaff.2017.1158.
[13] https://jamanetwork.com/journals/jama/fullarticle/2720014?resultClick=1.
[14] https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2021.pdf
[15] https://www.nachc.org/wp-content/uploads/2020/01/Chartbook-2020-Final.pdf

Seniors' access to care by the provider of their choice should not be compromised because of outdated federal barriers on NPs. Evidence shows that removing barriers to practice, including unnecessary supervision and other burdensome regulations, maintains patient safety, lowers health care costs and improves patient access to care. Removing barriers to care for NPs and their patients has garnered widespread bipartisan support. In addition to bipartisan support in Congress, reports issued by the American Enterprise Institute,[16] the Brookings Institution,[17] the Federal Trade Commission[18] and the U.S. Department of Health and Human Services under the past two administrations[19,20,21] have all highlighted the positive impact of removing barriers on NPs and their patients.

One of these barriers to practice falls under the home health care benefit in the Medicare and Medicaid programs. AANP has long advocated for a statutory change to authorize NPs to certify and recertify their patients' eligibility for home health care, fully establish and review home health plans of care and document the required face-to-face assessments. Under the current Medicare and Medicaid structure,[22] NPs can perform face-to-face assessments, but they must find a physician to document that the assessments have taken place, certify and recertify the plans of care and make plan of care changes. NPs who are the primary care providers for patients receiving home health care services are not able to initiate or make necessary adjustments to medication or treatment without obtaining physician signatures. This delays access to treatment and puts patients at risk for avoidable complications that can lead to increased ED visits and hospitalizations that increase health care costs. Delays in care are especially problematic for home health care patients who suffer from more chronic conditions and report more limitations

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[16] https://www.aei.org/wp-content/uploads/2018/09/Nurse-practitioners.pdf.
[17] https://www.brookings.edu/wp-content/uploads/2018/06/AM_Web_20190122.pdf.
[18] https://www.aanp.org/advocacy/advocacy-resource/ftc-advocacy.
[19] https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf
[20] https://aspe.hhs.gov/pdf-report/impact-state-scope-practice-laws-and-other-factors-practice-and-supply-primary-care-nurse-practitioners.
[21] https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-2018.pdf.
[22] 42 U.S.C. § 1395f(a); 42 U.S.C. § 1395n(a); 42 U.S.C. § 1395x(m)-(o)(2); 42 U.S.C. § 1395fff; 42 CFR Part 484; 42 CFR Part 410. These barriers also exist for certified nurse-midwives (CNMs), clinical nurse specialists (CNSs) and physician assistants (PAs), all of whom are included in the *Home Health Care Planning Improvement Act of 2019*.

on activities of daily living than the non-home health care Medicare beneficiary population.[23] NPs are already the largest residence-based primary care providers for Medicare patients.[24] Providing services under the Medicare home health care benefit without the need for physician certification is well within NPs' scope of practice.

Our members have seen first-hand the direct impact that these unnecessary certification requirements and the resulting delays in care have on your constituents. This begins with the initial certification where we've heard from rural hospitals advocating for this change so their patients can obtain the home health care that they need upon discharge, thus preventing rehospitalizations. The barriers then continue once a patient is receiving home health care and an NP is not authorized to make changes to the plan of care, such as ordering new medications or equipment, without a physician signature. Examples of the burden this unnecessary barrier puts on NPs and their patients include an elderly patient in Florida who fell and ended up in the ED because of delays in ordering a walker. An NP in Maine faced substantial administrative burden obtaining home health for her patients when she took over a large patient panel after several physicians retired from her practice. NPs in Pennsylvania who are patients' primary care providers for years, and then when their patients require home health services, they must find physicians to certify their plans of care and sign off on orders. In Washington, a patient with a glioblastoma needed a walker to assist with balance issues, but was delayed in receiving the walker due to the need for a physician signature. A patient with schizophrenia in Massachusetts was unable to get her medication adjusted, leading to frantic calls from her caregiver. These examples are just a few of the countless and unnecessary situations that play out for providers and patients each day due to these outdated requirements. It is important to note that NPs can order all of these services without a physician certification for their non-home health care Medicare patients.

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[23] http://ahhqi.org/images/uploads/AHHQI_2018_Chartbook_09.21.2018.pdf.
[24] https://www.ncbi.nlm.nih.gov/pubmed/28029709.

The Program for All-Inclusive Care for the Elderly (PACE)[25] and the Independence at Home Demonstration[26] have already shown that programs involving NP-led care for complex patients receiving care in their communities are cost-effective and improve patient outcomes. The Center for Medicare and Medicaid Innovation has recognized that authorizing NPs to document required face-to-face assessments, certify and recertify patient home health eligibility and establish and change home health plans of care will increase access to care and reduce health care costs by approving a home health care waiver for nurse practitioners as a component of Maryland's Total Cost of Care model.[27]

On behalf of our membership, our patients and their loved ones, AANP implores Congress to pass the *Home Health Care Planning Improvement Act of 2019* to modernize Medicare policy for *all* Medicare beneficiaries' and ensure that seniors have access to home health services without further delay.

Constituents from every state have seen the positive impact that removing barriers to practice for nurse practitioners has on patient access to care. As you are aware, P.L. 114-198, the *Comprehensive Addiction and Recovery Act of 2016* (CARA), granted nurse practitioners a five-year authorization to prescribe medication assisted-treatment (MAT) for opioid use disorder.[28] Recent studies have found that the number of NP MAT prescribers and the number of patients treated with MATs by NPs increased substantially in the first year that NPs were authorized to obtain their MAT waiver, with the largest growth occurring in the Medicaid population and rural communities.[29,30] This authorization was later made permanent in P.L. 115-271, the *SUPPORT*

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[25] https://www.npaonline.org/sites/default/files/3186_pace_infographic_update_121819_combined_v1.pdf. According to the National Pace Association, by 2016 half of PACE programs requested a waiver to allow an NP to lead the interdisciplinary team (IDT). *National Pace Association Comment on CMS-4168-P, October 12, 2016.* NPs were formally authorized to lead a PACE IDT without requiring a waiver as of August 2,2019. *See 84 FR 25610.* In this final rule, CMS noted broad support for this change.

[26] https://innovation.cms.gov/Files/fact-sheet/iah-yr5-fs.pdf

[27] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11330.pdf.

[28] CARA also granted a five-year authorization for PAs to prescribed MATs for opioid use disorder.

[29] https://www.macpac.gov/publication/analysis-of-buprenorphine-prescribing-patterns-among-advanced-practitioners-in-medicaid/

[30] In Rural Areas, Buprenorphine Waiver Adoption Since 2017 Driven by Nurse Practitioners and Physician Assistants: https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.00859.

*for Patients and Communities Act.*[31] Further, states that have moved to FPA, including Arizona[32] and Nevada,[33] have also reported positive workforce trends, including in rural areas, after removing barriers to practice.

With increasing rural hospital and facility closures, it is essential that we improve the home health care system to ensure that patients have timely access to medically necessary services in their communities delivered by their provider of choice. Patients who qualify for home health care should have the opportunity to choose the care setting that best meets their needs, and an increasing number of elderly patients are choosing their homes as their setting of choice.

AANP appreciates the Committee's examination of this issue. We believe it is essential to a robust health care system to ensure all providers are practicing to the full extent of their education and clinical training. We look forward to working together to ensure passage of the *Home Health Care Planning Improvement Act of 2019* to retire this needless barrier to patient access once and for all.

[31] The SUPPORT Act also made the authorization permanent for PAs, and granted CNMs, CNSs, and certified-registered nurse anesthetists a five-year authorization to prescribe MAT for the treatment of opioid use disorder.
[32] http://azahec.uahs.arizona.edu/sites/default/files/u9/azworkforcetrendanalysis02-06.pdf.
[33] https://www.healthaffairs.org/do/10.1377/hblog20181211.872778/full/.

**Statement for the Record**
**Submitted to**
**U.S. Senate Special Committee on Aging**
**February 12, 2020**
**On Behalf of the American Academy of PAs**

On behalf of the more than 140,000 PAs (physician assistants) practicing in the United States, the American Academy of PAs (AAPA) welcomes the opportunity to submit a statement regarding the February 12, 2020, hearing held by the U.S. Senate Special Committee on Aging on "There's No Place Like Home: Home Health Care in Rural America."

AAPA thanks Chairman Collins and Ranking Member Casey for holding this important hearing, and for continuing to shine a spotlight on an issue that impacts so many individuals and communities in the United States. Access to quality home health care is critical to ensuring patients receive personal care that is appropriate for them in the privacy and comfort of their own homes. Rural patients often depend on home health services to retain their independence and to avoid or delay hospitalization or a move to a nursing home or assisted living facility that may be a considerable distance from their community.

AAPA thanks the witnesses for both their testimony and their work in providing care to rural and underserved communities.

AAPA also thanks Chairman Collins for her years of dedication to improving access to home health services, particularly through her and Senator Cardin introducing S.296, the Home Health Care Planning Improvement Act of 2019. This legislation currently has 43 bipartisan cosponsors, including Ranking Member Casey, and would authorize PAs and other advanced practice providers to certify and manage home health care services for Medicare patients.

For many patients who face barriers to leaving the home and accessing care, home health services are the only way that they are able to receive lifesaving health care and maintain their independence. According to the Medicare Payment Advisory Commission (MedPAC), about 3.4 million Medicare beneficiaries received home care in 2017, which represents a significant increase since 2000. As America's population continues to age, it is critical for policy makes to ensure quality home health care services are available.

According to the Association of American Medical Colleges (AAMC), the U.S. will be facing a shortage of up to 122,000 physicians by 2032, with the shortage of primary care physicians ranging from 21,100 to 55,200. At the same time, the AAMC is projecting that the supply of PAs and advanced practice registered nurses will continue to increase. Per the National Rural Health Association (NRHA), "existing federal programs do not do enough to close this physician shortfall" and "additional actions must be taken to increase the supply of medical professionals in rural areas as the demand for their services is projected to increase in the future." Given their education and training, PAs are a vitally important part of the solution to this provider shortage.

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Enacting the Home Health Care Planning Improvement Act, S.296, would significantly improve access to home health services in rural and underserved communities, as well as promote continuity of care for the rapidly growing population of Medicare beneficiaries who rely on PAs and other advanced practice providers as their principal health care providers.

PAs are one of three types of health care professionals, including physicians and advanced practice registered nurses, who are recognized by the Medicare program to provide primary medical care in the United States. PAs are medical professionals who diagnose illness, develop and manage treatment plans, prescribe medications and serve as principal health care providers. PAs practice in every state, every medical setting and every specialty, and they are especially critical in ensuring access to care for rural and medically underserved areas. According to AAPA data, as of 2018 about 16% of all practicing PAs are located in a rural county, and multiple independent studies have shown that PAs practice in rural areas at higher percentages than many other providers. According to MedPAC, in 2017, 21% of Medicare beneficiaries in rural areas reported seeing a PA or NP for all or most of their primary care (versus 16% for the nation as a whole).

AAPA appreciates the important work being done in Congress, as well as the relevant federal agencies, to improve access to home health services in the United States. Far too many people in the United States face barriers to accessing home health services, with those in rural and underserved communities being particularly disadvantaged. PAs can play a vital role in ensuring that these rural and underserved communities are able to access home health services, along with a wide variety of other health care services.

AAPA is committed to working with Congress and all relevant federal agencies to improve access to primary care for underserved communities in the United States. Thank you for the opportunity to submit a statement for the record on this important issue, and please do not hesitate to contact Tate Heuer, AAPA Vice President, Federal Advocacy, at (571) 319-4338 or theuer@aapa.org with any questions.

Submitted Public Comment of Christopher E. Laxton, CAE, Executive Director,
AMDA – The Society for Post-Acute and Long-Term Care Medicine

Senate Special Committee on Aging
Hearing on "No Place Like Home: Home Health Care in Rural America"
February 12, 2020

Mr. Chairman, Ranking Member, and other Members of the Committee,

Thank you for holding this important hearing about home health care in rural America. I am the Executive Director of AMDA – The Society for Post-Acute and Long-Term Care Medicine. We are the only medical specialty society representing the community of over 50,000 medical directors, physicians, nurse practitioners, physician assistants, and other practitioners caring for our nation's most vulnerable patients and residents across the full spectrum of post-acute and long-term care (PALTC) settings. The Society's 5,500 members work in skilled nursing facilities, long-term care and assisted living communities, CCRCs, home care, hospice, PACE programs, and other settings. Our testimony focuses on our key priorities within the home health arena of interest to long-term care medicine.

We will focus on two areas that would directly impact access to care in rural areas.

Home Health Care Planning Improvement Act S. 296/H.R. 2150

Since 1965, Medicare law requires that a physician certify a patient's eligibility for coverage of home health services. Health care has changed since this Medicare provision was enacted. Primary care is often provided by non-physician practitioners such as Nurse Practitioners, Physician Assistants, and Clinical Nurse Specialists. To comply with the law, these professionals must "hand-off" their patients to a physician simply to comply with outdated Medicare certification requirements.

The Medicare Payment Advisory Commission (MedPAC) noted that, in 2017, 34% of Medicare beneficiaries received a billable service from a Nurse Practitioner, up from 16% in 2010. Similarly, the Journal of the American Medical Association (JAMA) found a narrowing gap between primary care NP and physician workforce supply over time, particularly in low-income and rural areas. These areas have higher demand for primary care clinicians and larger disparities in access to care. The growing NP supply in these areas is offsetting low physician supply and thus may increase primary care capacity in underserved communities. We believe the Home Health Care Planning Improvement Act would promote greater primary care work force availability in rural and underserved areas.

The Home Health Care Planning Improvement Act would allow Non-Physician Providers (NPPs) to certify a patient's eligibility for the Medicare Home Health Benefit. The bill would permit NPPs to establish and manage the patient's Plan of Care provided it is within the scope of their practice under state law. Finally, the bill would make NPPs eligible to certify the face-to-face encounter requirement. Ultimately, this bill should be viewed as a long overdue

modernization of the Medicare home health benefit. We urge the Senate to pass this important measure.

Telehealth

There is a growing body of evidence that greater use of telehealth services in post-acute and long-term care settings would help increase access to care in rural and underserved areas.

The Center for Medicare and Medicaid Services (CMS) has limited physician provided telehealth services in the long-term care setting to once every thirty days. This limitation stifles innovation and use of telehealth in the PALTC setting, which is vital to the continuum of care and where many seriously and chronically ill Medicare and Medicaid beneficiaries receive care.

For a busy PALTC clinician, if a single patient in a single nursing home 40 minutes' driving distance away has a change of condition, it may be unrealistic to make the trip and lose several hours of otherwise productive clinical time to see a single patient; this problem is exacerbated in rural areas. Further, many transfers occur at night and on weekends, when clinicians may be unavailable or may not have the necessary time or capacity to evaluate a patient's condition sufficiently to determine whether they should be sent to the hospital. In such instances, a telehealth visit may well prevent an unnecessary emergency room visit and would promote greater access to services, especially in rural areas. Allowing for such visits anytime there is a significant change in condition may allow for more timely clinician assessments of patients who need them.

We understand that patients in SNFs/NFs are complex and need to be seen by trained and qualified clinicians, but we believe previous concerns about the potential over-utilization of telehealth are simply outdated. Current research shows that telehealth allows patients to be monitored more closely and allows the clinician to evaluate and understand when a patient should be seen due to a change of condition. Research on the use of telemedicine nursing home patient changes in condition has demonstrated its potential to deliver high-quality care, and to reduce preventable emergency room visits and hospitalizations. We urge the Senate Special Committee on Aging to work with CMS to allow for more frequent telehealth reassessment of patients in the PA/LTC setting.

We thank the Senate Special Committee on Aging for the opportunity to provide feedback on policy for the most medically complex, frail elderly who reside in rural America, and we look forward to working with you to implement these changes.

AOTA® The American Occupational Therapy Association, Inc.

*Occupational Therapy: Living Life To Its Fullest®*

February 12, 2020

**RE: Testimony for the Record, Aging Committee Hearing, "There's No Place Like Home: Home Health Care in Rural America"**

Dear Chairman Collins and Ranking Member Casey,

The American Occupational Therapy Association (AOTA) is the national professional association representing the interests of more than 213,000 occupational therapists, occupational therapy assistants, and students of occupational therapy. The science-driven, evidence-based practice of occupational therapy (OT) enables people of all ages to live life to its fullest by promoting participation in daily occupations or activities. In so doing, growth, development and overall functional abilities are enhanced, while the impacts of illness, injury and disability are reduced.
We appreciate this opportunity to submit comments to the Senate Special Committee on Aging related to the February 12, 2020 hearing entitled "There's No Place Like Home: Home Health Care in Rural America."

Occupational therapy helps people participate as independently as possible in the necessary and desired activities that are a part of everyday life. Occupational therapy is unique in that it helps people function in all of their environments (e.g., home, work, school, community) and addresses the physical, psychological, and cognitive aspects of health and performance.

Among many skills, occupational therapy practitioners conduct home assessments to help ensure that beneficiaries can safely participate in the activities they consider most important. This is significant, as the Centers for Disease Control has identified occupational therapy led home modifications as the number one way to reduce costs associated with falls in the home.[1] Using a self-management approach, occupational therapy practitioners can help individuals to change their daily habits and routines to help better manage their chronic conditions, or to better manage pain. In addition, OTs work with people with dementia and their caregivers to focus on the person's remaining abilities, while also providing adaptations and modifications to help maintain participation for as long as possible.

**Unnecessary CMS Restriction Hinders Home Health Access in Rural Areas**

Rural Americans face unique healthcare challenges related to low population density, aging populations, long distances between patients and providers, and the corresponding low number of healthcare providers and professionals serving such areas. Long distances between patient and provider are of special concern to rural home health therapists who often drive from 100-200 miles per day visiting clients. In addition, home health agencies that serve rural populations generally have fewer therapists available, and this can cause service delays related to scheduling issues.

[1] https://doi.org/10.1016/j.amepre.2018.04.035

CMS regulations currently prohibit occupational therapists (OTs) from opening home health therapy cases. This can cause delays for Medicare home health providers, which are required to conduct an initial patient evaluation within 48 hours and a comprehensive evaluation within 5 days of receiving the home health order. The likelihood and impact of such delays are magnified for rural patients given the distances involved and number of home health therapists available. Additionally, OT may be the most appropriate discipline to perform that critical first home visit to evaluate the patient's environment to enable them to function safely at home.

The bi-partisan Medicare Home Health Flexibility Act (S1725/HR3127) would eliminate this restriction for therapy cases (where skilled nursing is not required). It is non-controversial and has been endorsed by the American Speech-Language-Hearing Association (ASHA), the American Physical Therapy Association (APTA) and the National Association of Home Care and Hospice (NAHC). Passage would help ensure a safer transition between facility and home, and reduce the likelihood that services could be delayed, or in some cases not provided at all.

**Medicare Part A, Patient-Driven Groupings Model**

While many home health agencies have been able to overcome the geographic and volume challenges of providing care in rural areas, the new Medicare Patient-Driven Groupings Model (PDGM) payment system, may create new challenges. On January 1, 2020, the Centers for Medicare & Medicaid Services (CMS) began reimbursing home health agencies (HHAs) for services based on patient characteristic data and functional level. Reimbursement is now no longer tied to the number of therapy visits as in the past. As a result, occupational therapy and other therapy services represent a "cost" for HHAs in providing home health services.

Since PDGM took effect on January 1, 2020, AOTA has had an open survey asking for input from occupational therapy, and other therapy practitioners, about their experience with PDGM implementation. From these surveys, it is clear not all home health agencies have responded to this payment change in the same way. However, stories of industry trends reported to AOTA and reported elsewhere[2] include:

- Mandated decreased number of OT visits,
- HHAs telling beneficiaries that they do not need OT in home health and can wait to receive OT in an outpatient setting,
- Shifting OT visits to physical therapy colleagues, and
- HHAs laying off or reducing therapy staff.

AOTA supports the intention of PDGM in trying to better align payments with beneficiary needs, however we are concerned the new system has resulted in decreased access to therapy services in some instances. We ask that the Committee work with CMS to ensure beneficiaries are receiving appropriate occupational therapy and home health services under this new payment system.

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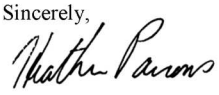
[2] https://khn.org/news/why-home-health-care-is-suddenly-harder-to-come-by-for-medicare-patients

Additionally, because Medicare regulations do not allow occupational therapists to open home health cases under Medicare Part A, occupational therapy services are more likely to be delayed or reduced under PDGM, despite the fact that these services focus on helping people with the critical skills they need for daily life. Passage of S.1725 would eliminate this unnecessary restriction and enhance the likelihood that a Medicare home health patient, especially in a rural setting, will receive timely occupational therapy services.

* * *

Thank you for the Committee's work on the important issue of Home Health Care in Rural America. If you need further information about the role of occupational therapy in home health care, the Home Health Flexibility Act, or our survey results about implementation of the PDGM, please do not hesitate to contact me at (240) 482-4147 or hparsons@aota.org.

Sincerely,



Heather Parsons
Vice President of Federal Affairs
American Occupational Therapy Association

**Statement for Hearing on: "There's No Place Like Home: Home Health Care in Rural America."**

**Submitted to the**
**Senate Special Committee on Aging**

**February 12, 2020**

Every American deserves affordable coverage and high-quality care. That is why America's Health Insurance Plans (AHIP)[1] appreciates the focus by the Special Committee on Aging focus on the important issue of improving access to health care in rural parts of the country. With approximately 20 percent of the total U.S. population living in rural communities, we must work together to ensure that they can receive the care they need when they need it.

Rural populations have different health care needs and face different challenges in getting care than those in urban and suburban areas. People living in rural communities have higher mortality rates from heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke, for example.[2] Doctors and other health care providers in these rural communities often face higher rates of "burn out" and are in short supply, and rural hospitals are closing at unprecedented rates.[3]

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[1] America's Health Insurance Plans (AHIP) is the national association whose members provide coverage for health care and related services to hundreds of millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities, and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers.

[2] https://www.census.gov/library/stories/2017/08/rural-america.html

[3] https://www.gao.gov/assets/700/694125.pdf; and https://www. shepscenter.unc.edu/programs-projects/rural-health/rural-hospitalclosures/

As part of their continued commitment to helping people get better when they are sick and to stay healthy when they are well, health insurance providers have developed innovative solutions to improve access to care in rural America. In this statement, we focus on the challenges with providing and delivering health care in rural communities, strategies that health insurance providers are employing to ensure rural populations have access to the care they need, and policy recommendations to ensure that Americans in rural communities have access to high-quality health care moving forward.

**The Challenges with Rural Health Care**

Serving remote regions with small and geographically dispersed populations poses unique challenges. In rural areas, individuals are often required to travel long distances to access care. Depending on where one lives, an individual may also face challenging environmental factors, such as extreme weather and poor driving conditions when accessing this care.[4]

These geographic challenges are often exacerbated by shortages of doctors and providers. Fewer doctors mean that fewer patients are able to promptly get essential care, including preventive care services. As a result, rural populations have lower rates of cancer screenings, immunizations, blood pressure checks, and diabetes screenings; higher rates of chronic conditions, including diabetes and obesity; higher rates of mental and behavioral health disorders; and, higher risk of injury.[5]

While these barriers may pose challenges for rural Americans of all ages, they can be particularly detrimental to older Americans. Increased age is often accompanied by a variety of health care challenges, including a greater prevalence of multiple and co-morbid conditions, which requires care from coordinated teams of physicians, nurses, social workers, family caregivers, and long-term care providers.[6]

Like hospitals, nursing homes in rural communities face financial instability and are increasingly shutting their doors or merging, often leaving some of the sickest and most frail seniors without a

[4] http://med.stanford.edu/ruralhealth/health-pros/factsheets/disparities-barriers.html
[5] https://www.cdc.gov/ruralhealth/about.html
[6] https://www.cdc.gov/aging/pdf/state-aging-health-in-america-2013.pdf

safe place to live long-term.[7] Small numbers of people and vast distances between homes also makes the delivery of home-based, long-term services and supports significantly more challenging. With one-quarter of all adults aged 65 and older living in rural communities, it is critical that we address these challenges.[8]

Other factors contributing to poorer health in rural communities include:

- Social barriers, such as a lack of access to healthy foods, housing insecurity, poverty, and a lack of access to education or employment;
- Structural barriers, such as insufficient public transportation,[9] poor availability of broadband internet services,[10] and a lack of available childcare;
- Greater prevalence of physically demanding and dangerous jobs in the agricultural sector;
- Greater likelihood of being uninsured;[11] and,
- High speed limits and poor-quality roads, which together contribute to higher rates of automobile accidents, the largest cause of unintentional injuries in rural America.

**The Role of Health Insurance Providers in Addressing these Challenges**

Health insurance providers are committed to ensuring that Americans living in rural communities have greater opportunities to experience better health outcomes. Solutions include investments in telehealth and remote patient monitoring, incentives to encourage more doctors to practice in rural and underserved areas, and innovative payment models to make care more efficient, affordable and sustainable.

**Telehealth and Remote Patient Monitoring.** With fewer doctors practicing in rural communities compared to suburban and urban communities, telehealth and remote patient monitoring play a critical role in ensuring that patients get the care they need, when they need it. Many health insurance providers partner with telehealth companies to connect patients with

[7] https://www.nytimes.com/2019/03/04/us/rural-nursing-homes-closure.html
[8] https://www.census.gov/newsroom/blogs/randomsamplings/2016/12/a_glance_at_the_age.html
[9] https://www.ncbi.nlm.nih.gov/pubmed/26025176
[10] https://annals.org/aim/article-abstract/2734029/limitations-poorbroadband-internet-access-telemedicine-use-rural-americaobservational
[11] https://www.census.gov/library/video/2019/rural-urban-uninsured.html

providers based on their needs. Other health insurance providers have relationships with their existing networks of providers to provide virtual access to care. Telehealth is often used to provide primary care, substance use disorder treatment, dermatology, medication management, radiology, and behavioral health care, among other specialties. Additionally, remote patient monitoring helps patients and their health care providers manage their chronic conditions, improve personalized care, expedite diagnoses, and reduce unnecessary emergency room visits. All of these services ultimately help to lower overall health care costs.

Examples of health insurance provider engagement in this area include:

- Anthem awarded a grant of $250,000 to the University of Virginia to expand specialty care to rural parts of Virginia via telehealth.
- Capital District Physician's Health Plans is expanding telehealth offerings to the underserved counties in New York.
- Blue Shield of California partners with telehealth companies and providers to increase access to specialty care in rural areas. This includes access to specialists in cardiology, dermatology, endocrinology, and rheumatology, among other specialties.
- Centene participates in the Global Partnership for Telehealth which links all of the counties in Georgia via a telehealth network, ensuring access to care throughout the state.

Telehealth and remote patient monitoring provide rural patients with access to care, but also allows patients the ability to remain at home and in their communities while receiving this care.

**Motivating Providers to Practice in Rural Communities.** Health insurance providers are also working to encourage more doctors to practice in rural communities. Many health insurance providers offer scholarships and financial incentives for providers to practice in rural and underserved areas. Examples include:

- Blue Cross Blue Shield of North Carolina awarded $800,000 to increase patient-centered primary care and recruit more providers to rural parts of North Carolina.
- Blue Cross BlueShield of Oklahoma, a division of Health Care Service Corporation, contributed funds to the Oklahoma Medical Loan Repayment program, which helps repay medical student loans of physicians in rural areas.

- Centene awarded twenty 1-year scholarships of $5,000 each to medical students at the University of Kentucky's Medical School and ten $8,000 per-semester scholarships to the University of Kentucky College of Nursing to encourage providers to practice in rural parts of the state.

**Building Innovative Payment Models.** Innovative payment models are another powerful tool that health insurance providers use to encourage providers to practice in rural communities. These payment models align payments to doctors with high-quality outcomes for patients while lowering the overall costs of care for everyone. Examples of such models include:

- Kaiser Permanente and CareFirst participate in the Maryland All-Payer Model Agreement, which uses value-based agreements to finance the state's hospitals. In a pilot program conducted in rural parts of Maryland, the state saw lower hospital readmissions, more resources for community supports, and general financial viability.
- Gateway Health, Geisinger Health Plan, Highmark, and UPMC Health Plan are working with the Department of Health and five hospital systems in Pennsylvania to create a global budget model and address economic challenges in rural communities. The aim of this model is to create more economic stability for rural providers while shifting to value-based care.
- Blue Cross Blue Shield of Michigan is designating small, rural acute care facilities eligible for Hospital Pay-for-Performance incentives. This program provides these hospitals an opportunity to demonstrate their value by meeting access, effectiveness, and quality of care goals. For 2019-2020, incentives can comprise up to 6 percent of a hospital's payment.

## Next Steps: Policy Recommendations to Improve Access to Care in Rural America

Health insurance providers and the private market are developing real solutions that address the specific health care needs of rural Americans. Policymakers can further advance this work by embracing additional comprehensive, multi-stakeholder approaches:

**1) Offer additional programs and incentives to encourage providers to practice in rural and underserved communities.**

The federal government can build on the foundation established by health insurance providers to authorize loan repayment and other incentive programs for physician assistants and nurse practitioners who agree to practice and deliver care in rural communities. The federal government also could establish grants for providers to practice in rural communities on a volunteer basis, either through the expansion of the National Health Service Corps or through the creation of new programs. Another way to address provider shortages would be to remove the caps on the number of residents funded by Medicare and increase Medicare-funded residency positions. By removing these caps, rural hospitals could use Medicare payments to offset costs associated with training physicians during residency.[12]

**2) Expand access to care through telehealth.**

Policymakers can increase the availability of telehealth by establishing multi-state licensure compacts. This would expedite licensure for physicians and/or grant reciprocity for certain providers across multiple states, increase the types of specialists offering services, and expand provider networks available to consumers.

Policymakers could also enhance innovation and flexibility by avoiding state mandates related to reimbursement and/or payment parity, site-specific use, prior visit requirements, or specific technology use. Inconsistent state laws and mandates can hinder access to telehealth services limiting flexibility to design benefits that meet the needs of consumers.

Telehealth could also be designated as a means of satisfying health insurance network adequacy requirements. Under 45 CFR 156.230, the Department of Health and Human Services (HHS) could establish telemedicine as an option to meet federal requirements for network adequacy standards. In a 2016 revised model law, the National Association of Insurance Commissioners included the use of telemedicine as an option to meet network adequacy standards.

Additionally, federal legislation should permit first-dollar coverage of telehealth services in health savings account (HSA)-eligible health insurance providers. Permitting health insurance

[12] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/DGME.html

providers to cover telehealth services with first-dollar coverage reduces overall costs to the system and allows greater flexibility and affordability for Americans.

**3) Make insurance coverage more affordable in rural communities.**

Many Americans living in rural communities do not have access to employer-provided coverage and do not qualify for Medicaid or Medicare, leaving the individual insurance market as their only option for coverage. In 2019, nearly one-in-five HealthCare.gov consumers lived in a rural area.[13] Unfortunately, for Americans who don't qualify for financial assistance with individual market premiums and/or cost sharing, individual market coverage may be unaffordable. States could implement reinsurance programs for the individual market to reduce premiums. Moreover, if Congress enacted a permanent federal reinsurance program, it would provide the benefits of reinsurance nationwide without the need for each state to seek a federal 1332 waiver.

**4) Promote good heath practices for people and communities.**

Policymakers at both the federal and state levels should work with stakeholders to promote community-based efforts to address underlying issues that contribute to health, education, and income disparities in rural areas. Virtual prevention and public health initiatives have been proven effective in addressing issues faced by underserved rural communities, including American Indian and Alaska Native populations.[14] Existing virtual prevention and public health programs that demonstrate effectiveness should be expanded to other high-risk rural populations and to other rural regions to further promote healthy living. In addition, public education programs should be provided for patients, families, communities, and providers to better understand pain management options, the benefits and potential risks of prescription opioids, and potential risk factors for addiction.

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[13] https://www.cms.gov/newsroom/fact-sheets/health-insuranceexchanges-2019-open-enrollment-report
[14] https://www.ihs.gov/hpdp/

**Conclusion**

Every American deserves to have access to the care they need when they need it—regardless to where they live. Effectively policy solutions exist, but implementation will require collaboration among a number of stakeholders at the federal, state, and local levels and with the private sector. Health insurance providers understand the importance of ensuring Americans in rural communities have access to care, particularly given the unique challenges they face. By working together, we can ensure that everyone in our communities can get the care they need at a cost they can afford, leading to improved health and well-being and enhanced financial security. AHIP thanks the Committee for focusing on this important issue, and we look forward to working together on initiatives to improve health care in our rural communities.

February 21st, 2020

The Honorable Susan Collins
Chairman
Senate Special Committee on Aging
G31 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Robert Casey
Ranking Member
Senate Special Committee on Aging
G31 Dirksen Senate Office Building
Washington, DC 20510

*Submitted electronically*

**Re: Submission of Statement for the Record, Senate Special Committee on Aging Hearing, "There's No Place Like Home: Home Health Care in Rural America"**

LeadingAge, the association of mission-driven, aging focused service providers, and our partners, the Visiting Nurse Associations of America (VNAA) and ElevatingHOME (EH) appreciate the opportunity to submit a statement for the record related to the February 12th, 2020 hearing "There's No Place Like Home: Home Health Care in Rural America."

The mission of LeadingAge is to be the trusted voice for aging. Our 6,000+ members and partners include nonprofit organizations representing the entire field of aging services, including affordable housing, assisted living, home care, life plan communities, and nursing homes. LeadingAge partners with 38 state associations, hundreds of businesses, consumer groups, foundations and research centers. LeadingAge is also a part of the Global Ageing Network, whose membership spans 30 countries. LeadingAge is a 501(c)(3) tax-exempt charitable organization focused on education, advocacy and applied research through our LTSS Center. As part of our efforts, we have a Center for Workforce Development, a Center for Aging Services Technologies (CAST), and a Center for Managed Care Solutions all of which develop targeted resources for and about our members that intersect with the issues that the Committee tackled in this hearing and in their jurisdiction generally.

ElevatingHOME and its subsidiary VNAA, share the mission of advancing high-quality, patient-centered health care that starts in the home. ElevatingHOME members are mission-driven home health and hospice providers serving rural, urban and underserved communities across the nation. ElevatingHOME members provide cost-effective and compassionate care to the most vulnerable individuals, including older people and persons with disabilities.

We applaud Senator Collins and Senator Casey's leadership of this Committee. Senator Collins has long been a leader in aging services writ large and in particular supporting the home health community. We strongly support both the *Home Health Payment Innovation Act (S.433/ H.R. 2573)* which would ensure payment adequacy for home health providers and expand flexibilities in the home health benefit and *The Home Health Care Planning Improvement Act (S.296/H.R. 2150)* which would expand the providers that can order home health services beyond a physician and thus expand the ability of home health to be offered in rural and underserved areas.

We applaud the introduction of Senator Casey's *Home and Community-Based Services (HCBS) Infrastructure Improvement Act (S. 3277)* which will provide financial investments to states to build

HCBS infrastructure in several our key priority areas related to rural healthcare: workforce, transportation, housing, and caregiving.

We offer the following specific comments for your consideration.

***Workforce***

The United States has a significant shortage of, and a growing demand for, qualified workers who are capable of managing, supervising and providing high-quality services and supports for older adults and this shortage is endemic in the rural and underserved areas. The population of adults age 65 and older will increase from nearly 50 million in 2015 to 88 million in 2050 – an 84% increase. Among those currently reaching retirement age, more than half (52%) will require long-term services and supports (LTSS) at some point, and for an average of two years. By 2050, the number of individuals using paid long-term services in any setting will likely double from the 13 million who used services in 2000, to 27 million people. [1] The direct care workforce nearly doubled from 2.9 million in 2008 to 4.5 million in 2018. Another 1.9 million will be needed by 2028.[2]

State governments are grappling with the workforce crisis as well as the federal government. For example, the Maine Legislature convened a commission in 2019, in recognition of the tight labor market and resulting workforce shortage of direct care workers across the LTSS continuum including home and community-based services, residential services and other support services. The Commission released a report January 2020, "Commission to Study Long-term Care Workforce Issues," which included suggested legislation to the Joint Standing Committee on Health and Human Services that address workforce recruitment and retention, workforce development, reimbursement, training and several other areas that address barriers to implementing their recommendations. An analogous body in Pennsylvania, the Pennsylvania Long-Term Care Council, released its "Blueprint for Strengthening Pennsylvania's Direct Care Workforce," in April 2019 that contained recommendations related to public awareness, wages, career pathways, technology, and several other areas.

Unfortunately, current recruitment and retention of workers of all kinds is an ongoing challenge for several reasons, including inadequate funding under public programs and the physical and emotional demands of the work. An unstable workforce creates high provider costs, and concerns about access and quality. While LeadingAge, VNAA/EH, and its members continue efforts to improve our field's workplace culture and share best practices through our LTSS Center at UMass Boston and Center for Workforce Solutions, changes in public policy are needed to ensure adequate numbers of well-trained and qualified caregivers now and in the future.

LeadingAge has long advocated for domestically based solutions to the LTSS staffing crisis. In addition, in October 2019 we proposed the International Migration of Aging and Geriatric Workers in Response to the Needs of Elders (IMAGINE) initiative. This multifaced workforce initiative features a set of targeted policy recommendations aimed at engaging qualified foreign-born workers through targeted visa programs. These include:

- ✓ **Aging Services Guest Worker Program**: We support the introduction and enactment of a "H2Age" temporary guest worker program for certified nurse aides and home care aides.

[1] https://www.leadingage.org/sites/default/files/LA_Workforce_Survey_Whitepaper_v5.pdf
[2] https://phinational.org/resource/its-time-to-care-a-detailed-profile-of-americas-direct-care-workforce

- ✓ **J-1 Cultural Exchange Visa Changes:** We support the introduction and enactment of Cultural Exchange Visa changes to include aging services workers, in addition to childcare workers.

- ✓ **Modify EB-3 Visas for Nurses:** We support expanding and modifying visas to support improvements to increase the quotas for foreign-born LTSS nurses**.**

- ✓ **Expand "Religious Occupation" to Include Aging Services:** We support modifying the R-1 program to cover temporary workers so it includes include aging services settings.

In addition to Senators' Collins and Casey aforementioned legislation, there is existing legislation that would support workforce needs that we ask that the Committee consider and recommend to other Committees of Jurisdiction for action:

- ✓ *Ensuring Seniors' Access to Quality Care Act (S. 2993)* that would allow reinstatement of a nurse aide training program once a nursing home has been determined by CMS to be in substantial compliance. The current policy which results in the loss of nurse aide training authority is an obstacle to quality improvement for nursing homes that need to increase their staffing levels and exacerbates the severe workforce shortage in long-term care especially in rural areas where there often are no alternative training sites.

- ✓ *The Rural Access to Hospice Act (S.1190/H.R. 2594)* would allow rural health centers and federally qualified health centers (FQHCs) to receive payment for physicians' services while acting as attending physicians for their patients in hospice care.

- ✓ *EMPOWER for Health Act of 2019 (H.R. 2781)* that reauthorizes the Geriatrics Workforce Enhancement Program (GWEP) and Geriatrics Academic Career Awards (GACA) program to provide training to students, faculty, providers, direct service workers, patients, and families to address gaps in health care for older adults.

- ✓ Reauthorize the Older Americans Act (*The Dignity in Aging Act (H.R. 4334)*) which includes many provisions that impact rural areas but in particular includes a provision that allows projects to improve the direct care workforce to be on the list of authorized demonstration projects implemented by the Administration for Community Living. This bill has passed the House and is awaiting a vote in the Senate.

- ✓ *Direct Care Opportunity Act (S. 2521/H.R. 4397)* that directs the Department of Labor to award grants to recruit and provide advancement opportunities to direct care workers.

***Reimbursement***

The Committee should consider the following options related to reimbursement that would support providers in rural areas, particularly those serving patients in their homes:

- ✓ Create reimbursement parity between critical access hospitals (CAHs) and other post-acute providers providing the same services.[3]

- ✓ Make the rural add-on payment for home health care permanent. Senator Collins is a great champion for this policy, and we thank her for mentioning the rural add on at the hearing. We look forward to continued work on this issue in home health and want to explore rural add-ons for other providers such as skilled nursing facilities, hospices, and adult day providers.

- ✓ Explore the creation of a disproportionate share program or a FQHC-like reimbursement for new categories of providers in rural communities.

- ✓ Expand the wage index[4] geographic reclassification board[5] to include non-hospital providers. Of concern is that a hospital may secure a geographic reclassification for application of the wage index by establishing that said hospital draws on an employment pool that is different from the geographical area to which it would otherwise be assigned. As a result, a hospital competing for the same employees as home health and hospice providers may be receiving more Medicare monies and thus have more funds to pay staff.

- ✓ Expand the wage index protections offered to hospitals to other Medicare providers. For example, a home health or hospice's wage index can be below the "rural floor" for their state; this cannot be the case for a hospital.

- ✓ The Committee should also consider a process by which providers in rural and underserved communities could apply for some of the waivers allowed for in the Center for Medicare and Medicaid Innovation (CMMI) demonstrations like the homebound requirement in home health, the 3-day requirement for SNF stays, and others to increase volume.

- ✓ Specialized Staff Training: At Garden Village in Yakima, Washington, most of the residents have severe behavioral health needs and 92% of the facility's payments come from Medicaid. Residents with behavioral health diagnoses need staff with specialized training and supports that require different policies. Staff is specially trained from day one to interact with residents who are behaviorally challenged. The Committee should look at how to adjust reimbursement and oversight to support this type of nursing home – and other providers who serve specialized populations in their communities – what makes for a good community for those with behavioral challenges does not necessarily fit into a surveyor's checkbox.[6]

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[3]Post-acute care has changed significantly since the establishment of the CAH program and many rural nursing homes have transitional care units that can get the same outcomes at a lower cost to the federal budget.
[4]CMS made some substantial updates to the wage index in the 2020 IPPS Final rule but we do not anticipate that these changes will address the problems outlined here.
[5]Medicare home health and hospice providers payments are adjusted to reflect varying wage levels across the nation using a wage index; however the wage index utilized by CMS is based on the reporting of hospital wages that explicitly excludes any home health or hospice specific service costs.
[6]https://www.leadingage.org/catalysts/september-2019-leadingage-catalyst

***Technology***

Through CAST, LeadingAge supports our members in expediting the development, evaluation, and adoption of emerging technologies that can improve the aging experience. CAST produces resources that states, regional networks, or other entities can use to address a variety of technology challenges from electronic health records to medication management tools to care planning tools.

The CONNECT for HEALTH Act (S.2741/H.R. 4932) would be a critical step forward in expanding evidence for and access to telehealth:

- ✓ The waiver in this legislation that would allow for more flexibility around telehealth use in high-need professional shortage areas could have an immediate impact on workforce shortages.
- ✓ We are also very supportive of the MedPAC study and demonstration proposals in the legislation that would allow for testing of how telehealth is most effective and what sufficient reimbursement looks like for a variety of telehealth services.

- ✓ Allowing hospices to provide the face-to-face recertification via telehealth would also alleviate burdens particularly on rural hospice providers.

- ✓ The use of telehealth for mental health and emergency care would help all our providers in rural and underserved areas where having access to these services via telehealth may prevent a hospitalization (and a long ambulance trip).

***Other Areas for the Committee's Consideration***

*Supporting Communities:* Hospice providers are required to provide grief counseling as a part of the Medicare Hospice Benefit. Many nonprofit hospice providers extend those benefits into their communities at large, offering grief and bereavement support to those who need it regardless of whether they have received care from the hospice provider – these services are philanthropically funded. In response to increased deaths from substance abuse disorders, especially related to opioids, nonprofit hospices have been utilizing their grief counselors to address issues related to treating adults and children affected by an unintended overdose death. These efforts are stretching the abilities of the hospice programs to continue these services and the impact is causing many to discuss the viability of the maintaining services at this level. These services give tremendous support and guidance for individuals, many of whom already live in destructive environments. The Committee could consider funding opportunities not only for preventive efforts but supportive efforts like these so that families can begin to recover.

*Lack of access and lack of means to pay for services:* LeadingAge represents many rural long-term services and supports providers who do an outstanding job in caring for their residents and clients. Residents of rural areas need and deserve the highest quality of long-term services and supports. But the challenges of financial and human resources that generally prevail in the long-term services and supports field are magnified in rural and frontier areas where the working-age population is declining, the aging population is growing, and health, long-term care, and human resources are few and far between. Residents of rural areas have less access to hospice services and have uneven access to home

health services amongst many other examples.[7] This is a concern not only for us as providers but also for those representing individuals and families who need long-term services and supports.

In addition to the bills we mentioned earlier in this statement, we support the Homecare for Seniors Act (S. 3261/H.R. 2878) (sponsored by Committee member Senator Sinema and we thank her for mentioning it during the hearing) which would allow for monies from health savings accounts to be used to pay for certain qualified homecare expenses. We also believe that more comprehensive long-term services and supports financing reform is needed to ensure that people at all economic levels are able to access services when they need them.

LeadingAge and VNAA/EH thank the Committee for holding this hearing and looks forward to partnering to ensure access to high quality care across settings in rural communities.

Please contact Ruth Katz, Senior Vice President for Policy and Advocacy, LeadingAge, with any follow-up questions or comments at rkatz@leadingage.org

Sincerely,

Katie Smith Sloan
President & CEO
LeadingAge

Acting President & CEO
Visiting Nurse Associations of America and ElevatingHOME

[7] http://medpac.gov/docs/default-source/reports/mar19_medpac_ch12_sec.pdf?sfvrsn=0 and http://medpac.gov/docs/default-source/reports/mar19_medpac_ch9_sec_rev.pdf?sfvrsn=0

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